

REPORT TO CONGRESS

**AMBULATORY SURGERY, PREADMISSION TESTING, AND SAME-DAY
SURGERY: STATE MEDICAID PROGRAMS' EXPERIENCE
AND FINDINGS FROM THE LITERATURE**

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INTRODUCTION

Section 4755(b)(1)(C) of Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990, OBRA-90 prohibited the Secretary of Health and Human Services from publishing "regulations requiring a State plan approved under title XIX of the Social Security Act to include a program for ambulatory surgery, preadmission testing, or same-day surgery". Instead, section 4755(b)(3)(d) required that the Secretary submit a report containing:

"(1) an analysis of the procedures for which programs for ambulatory surgery, preadmission testing, and same-day surgery are appropriate for patients who are covered under the State medicaid plan, and

(2) the effects of such programs on access of such patients to necessary care, quality of care, and costs of care."

To carry out the mandate, the Health Care Financing Administration (HCFA) contracted with Mathematica Policy Research, Inc. (MPR) to conduct a review of the extant literature to ascertain what is known of the impact of these programs on patients' access to services, the quality of care, and the cost savings derived from their implementation. MPR was also asked to conduct a survey of State Medicaid agencies to find the extent to which these programs are in place and the States' assessment of their impacts on access, quality, and program costs. Though this report relies heavily on MPR's findings, it is supplemented by inputs provided by HCFA staff. MPR's literature review and final report is included as Appendix A to this report. The need for regulations requiring the States to adopt ambulatory surgery, preadmission testing, and same-day surgery policies is examined in light of the findings.

BACKGROUND AND CONTEXT

The three utilization management methods constituting the subject of this report were conceived in response to rapidly rising health care costs. They were instituted by private and government health insurance programs as measures that would reduce the rate of increase in health care costs by shifting the locus of medical services from hospital inpatient departments to less costly outpatient settings. The adoption and diffusion of these measures started in the 1970's and have continued to the present. These utilization management methods work directly on medical management decisions by requiring their use when medically appropriate.

The 1980's saw Medicare's initiation of its prospective payment system for inpatient hospital services based on diagnosis related groups (DRGs) and the proliferation of health maintenance

organizations and other managed medical care systems paid on a capitation basis. By 1992, 21 States had adopted the DRG-based payment system for their Medicaid programs.

Seven of the 10 highest Medicaid expenditure States had adopted the DRG-based payment system. The 21 States using the DRG-based system accounted for 53.4 percent of aggregate Medicaid spending (Carter, et al., 1994). As of June 30, 1993, 3.3 million Medicaid beneficiaries were enrolled in various prepaid capitation plans (U.S. Department of Health and Human Services, 1993).

The adoption of prospective payment systems for hospital services and the growing enrollment of Medicaid beneficiaries in capitated health plans introduce economic considerations into medical decision-making. A prospective payment system and capitation payments put a cap on the revenues to be derived from the provision of services to patients covered by such systems. The provider of services derives financial benefit by reducing the cost of providing the necessary services. To maximize net income, the provider needs to consider the appropriateness of ambulatory surgery, preadmission testing, and same-day surgery in planning the patient's care.

The operation of financial incentives could work to the disadvantage of the patient through the non-provision of needed inpatient services (i.e., access) or the stinting of resources in the provision of the service (i.e., quality of care). Therefore, the congressional mandate required that this report also examine whether the use of ambulatory surgery, preadmission testing, and same-day surgery adversely affect the quality of care and access of patients. The methodology followed by MPR is described next.

METHODOLOGY

The methodology used by MPR had two components:

- (1) A comprehensive literature search and review of writings pertaining to ambulatory surgery, preadmission testing, and same-day surgery. This was carried out through a systematic, on-line search of computerized data bases and printed sources. Organizations and individuals familiar with issues related to these cost-containment measures were contacted and interviewed.

- (2) A mail survey of State Medicaid agencies. A packet of questionnaires was mailed to the Medicaid directors in all 50 States and the District of Columbia. In addition to containing questions pertaining to ambulatory surgery, preadmission testing, and same-day surgery, the packet included questions about 7 other utilization management

methods: second surgical opinion, preadmission certification, lock-in, high-cost case management, primary care case management, targeted case management, and rebundling (Note: these terms are defined in this report's Glossary). This was done to acquire a perspective on the use of the three utilization management methods which are the focus of this report relative to the 7 other methods that are used (i.e., reference to the other methods will be made as they are germane to the focal three).

Responses were received from 49 of the 51 queried agencies. Because a few States did not respond to program-specific questions on one or more programs, the specific response rates for the three programs covered in this report were 97 percent for ambulatory surgery, 100 percent for preadmission testing, and 93 percent for same-day surgery. The relationships and implications of payment methods on the use of these utilization management methods were not explored in the survey.

FINDINGS

Of the 10 utilization management methods covered by the survey, 1 State had none in place and 3 had 9 in place. No State had all 10 in place. The modal number of methods in place was 4 in 11 States and 5 in 12 States.

The findings with respect to the focal three utilization management methods will be presented in two parts. First, the findings related to the use of ambulatory surgery policies will be presented. This will be followed by the findings on the use of preadmission testing and same-day surgery policies. The reason for integrating the latter two methods into one discussion is that both employ the same cost reduction strategy--the encouragement of routine diagnostic testing on an outpatient basis prior to inpatient admission for treatment and/or surgery.

The presentation of the findings will include: the underlying rationale(s) for the program, the number of States using the program, and assessments of the program's impact on expenditures, quality of care, and access.

AMBULATORY SURGERY

Underlying Rationale

The development, acceptance, and diffusion of ambulatory surgery programs arose from several technical and economic sources:

1. The shift of procedures from the inpatient to the outpatient setting has been made possible by such advances in

medical science and technology as: the development of anesthetics that act rapidly and leave few prolonged side effects such as drowsiness and nausea; the use of short-acting narcotic and non-narcotic analgesics to treat pain and drugs to manage nausea and vomiting, thus reducing patient discomfort after surgery; physicians encouraging patients to become ambulatory soon after surgery, leading to reduced recovery time; the development and use of more sophisticated equipment and techniques such as endoscopy and laser surgery broaden the range of procedures that can be feasibly performed in ambulatory settings.

2. Ambulatory surgery programs eliminate the need for an inpatient stay and the associated hospital room and board costs. This provides prima facie evidence that outpatient settings are less expensive than an inpatient admission would be for the same procedure.

3. The shift of procedures to the outpatient setting results in a concomitant decrease in the number of inpatient admissions for the same procedures, and, thereby, reducing the expenditures for inpatient hospital services.

Coverage of ambulatory surgery by the Medicare program distinguishes between procedures that can usually be performed safely in a physician's office and those that require a more elaborate array of equipment and support services not normally found in physicians' offices, but do not require an inpatient hospital admission. These intermediate facilities are generically known as ambulatory surgery centers. They may be part of a hospital's outpatient department or they could be freestanding. Payment for procedures in these centers include a facility cost component as well payment for the physician's professional service. A procedure performed in a physician's office is covered by the physician's fee only. The procedures covered by Medicare when done in an ambulatory surgery center are listed in Appendix B.

As part of the survey, the States were asked to send a listing of the procedures that they covered when performed on an ambulatory basis. Fourteen States sent such a list. Three of the States used Medicare's listing. Two of the States used nomenclature and codes that differed from Medicare's but seemed to make the same distinction by appropriateness of site as does Medicare. The listings received from seven States seemed to include all procedures that would be covered when performed in an ambulatory setting without differentiation by site. One State sent only a partial listing "not meant to be all-inclusive." The remaining State sent a printout of procedures done in an ambulatory setting that had been paid by the State. There was no indication whether other procedures would be covered or whether a distinction between physicians' offices and ambulatory surgery centers had been made. The survey identified 32 States with ambulatory surgery policies.

Impact on Program Costs

The expectation that precluding an inpatient stay for a given procedure would provide cost savings for the Medicaid program was borne out by MPR's review of the literature and survey of the State administrators. However, MPR did express some reservations about this finding because many of the studies were methodologically flawed. Most of the available studies date from the late 1970's and early 1980's, and do not reflect the more sophisticated procedures that are now performed in outpatient settings. Also, though most survey participants attributed savings to ambulatory surgery, few were based on careful evaluations. Hence, while it is likely that there are cost savings derived from the shifts of procedures from an inpatient to an outpatient setting, the magnitude of the savings cannot be estimated. This is especially true since hospitals have been making significant progress in containing increases in inpatient costs. In terms of instituting ambulatory surgery programs in States where they do not exist, some States believed other utilization management methods may be more effective. Other utilization management programs were rated as "strongly effective" in reducing costs by more States than was ambulatory surgery.

Impact on Quality of Care

In terms of post-surgical complications, the studies reviewed by MPR found very little, if any, difference between outpatient and inpatient settings. In terms of patient satisfaction, researchers found a higher level of satisfaction among patients treated in outpatient settings. MPR expressed reservations about the inferences to be drawn from the literature review because of the absence of recent studies and the increased complexity of the procedures now being performed in an outpatient setting. However, none of the survey participants reported an adverse impact on the quality of care from surgery performed in ambulatory settings.

Impact on Access to Care

MPR could find no studies that specifically addressed the question of whether ambulatory surgery affected access to care. However, in the course of addressing other issues, some writers have asserted that ambulatory surgery increases access to care by: (1) increasing the choices available to patients, (2) making surgery more convenient as a result of the shorter periods that patients have to be away from home and work, and (3) lowering the cost of the procedures. The latter may not be relevant for Medicaid beneficiaries since the program would be making the payment.

None of the State survey participants perceived a negative impact on access. MPR raises the possibility of a perverse impact on access if special authorization is required to perform certain procedures on an inpatient basis if: (1) the patient has health problems that increase the risk of ambulatory surgery, and (2) special preoperative and postoperative instructions have to be followed with the help of family members. Medicaid beneficiaries may be more likely to present these problems than non-Medicaid patients.

SAME-DAY ADMISSION SURGERY AND PREADMISSION TESTING PROGRAMS

Underlying Rationale

Both programs reduce inpatient hospital costs by decreasing the length of inpatient stays. Stays are shortened by eliminating early admissions for routine testing and identifying previously undiagnosed conditions that can delay surgery and/or prolong hospitalization. Optimally, when the patient is admitted, the patient's condition is understood and treatment and/or surgery can proceed with minimal delay.

The survey found 15 States with same-day admission surgery policies and 11 States with preadmission testing policies.

Impact on Program Costs

MPR did not find an extensive literature on the impact of same-day surgery or preadmission testing on health care costs. Two studies of the impact of same-day surgery found that patients admitted for same-day surgery had a length of stay two days less than routinely admitted patients. This shorter length of stay resulted in cost savings. No studies were found that specifically examined the impact of preadmission testing on health care costs. Under Medicare's DRG payment system, preadmission tests performed within 72 hours of admission do not entail any additional payments for that inpatient episode.

It was found that there is general agreement that shifting tests to outpatient settings saved money. This general agreement is evident in the finding that preadmission testing programs were among the most prevalent cost-containment measures adopted by employers. In 1984, 87 percent of 170 employers covered in a survey by the Wyatt Company used preadmission testing. MPR found that hospitals and physicians now rarely admit patients for preoperative testing.

While preadmission testing is widely accepted, there is evidence that preadmission testing policies could produce additional savings if they focused on reducing the number of diagnostic tests performed. In 1984, Blue Cross/Blue Shield estimated that of the \$30 billion spent on preoperative testing in the United

States that year, \$12 to \$18 billion could have been saved if the only tests performed were those indicated as necessary by the patient's medical history. There is some indication that a movement toward the selective use of preoperative tests is beginning.

Although the survey found relatively few States had preadmission or same-day surgery policies (11 and 15 States, respectively), those with programs in place stated that they had beneficial effects for controlling costs. However, States differed in whether they encouraged or required preadmission testing and in whether payments were denied for non-compliance. Among States that did not have these programs in place, there was little interest in their adoption. Almost one-third of the States without a same day surgery policy believed the cost of implementation would exceed its benefit.

The impact of prospective payment systems for inpatient hospital services and the spread of capitated enrollee groups on the use of preadmission testing and same-day surgery practices was not examined by the survey. Both payment systems provide incentives to physicians and hospitals to follow cost-reducing practices. As noted above, hospital admission for preoperative testing is rare, today. It seems plausible to infer that the use of payment mechanisms may be as, if not more, effective than direct policy requirements in inducing cost-effective medical practice.

Impact on Quality of Care

The literature review did not find any articles that specifically examined the impact of shifting preadmission/preoperative diagnostic tests from the inpatient to the outpatient setting on quality of care. However, MPR found a general consensus that the quality of such tests had not been compromised by the shift in site. Among survey respondents with preadmission testing and same day surgery policies, no adverse effects on quality of care were reported and some noted improvements. MPR noted that the movement toward the selective use of preoperative tests, while promising cost savings, also show promise of not adversely affecting quality of care.

Impact on Access to Care

The literature review found no direct evidence of any adverse impact of preadmission testing or same-day surgery on access to care. The survey respondents reported no adverse impact of the programs on access. A few State respondents perceived improved access. On a conceptual basis, MPR posited circumstances where these programs could affect access to care. If all the preadmission/preoperative tests could not be completed in one visit, additional transportation costs would be incurred which could affect access because of the Medicaid beneficiary's

low-income status. However, no studies examining this possibility were found. Ways of dealing with this potential problem have been developed in a preadmission testing program developed by the Johns Hopkins Medical Center.

CONCLUSION

Despite reservations about the studies reviewed, MPR found that all three utilization management programs studied for this report reduced program costs by reducing the use of inpatient hospital services. Ambulatory surgery works by precluding the need for an inpatient admission for a range of surgical procedures that can be safely performed on an outpatient basis. The number of such procedures has increased significantly over time.

Preadmission and preoperative testing are cost-effective because diagnostic testing is less expensive on an ambulatory basis than if done on an inpatient basis and incurring hospital room and board charges. The available data do not permit an estimate of the potential cost savings in today's health care market, place. Most such cost-saving studies were done in the late 1970's and early 1980's.

The major dynamic affecting the use of these utilization management methods may not be their direct impact on medical decision-making by regulation, but rather the effect of new payment mechanisms that shift the consideration of costs to the provider of services as much as on the payers. The prospective payment system based on DRGs provides strong incentives to hospitals to provide needed services at lower costs. As of June 30, 1993, there were 21 State programs that used this system to pay for inpatient hospital services. The proliferation of managed care systems paid on a capitation basis also increases providers' sensitivity to costs. In addition, there is no clear evidence that either quality of care or access to care have been adversely affected by these payment arrangements.

In light of these considerations the Department of Health and Human Services does not plan to issue, at this time, regulations requiring State Medicaid programs to adopt policies for ambulatory surgery, preadmission testing, and same-day admission surgery. The Department believes the States have every incentive to develop their own utilization management programs from among the range of possibilities that exists. This would allow them to choose those programs that they determine to be cost-effective given their resources, characteristics of the local health care system, and perceived relative effectiveness compared to other utilization management programs.

Overarching the use of direct utilization management programs by the States is the impact of the new ways that providers are being paid to render health care services to Medicaid beneficiaries.

Prospective payment systems for services and capitation payments for beneficiaries enrolled in managed care programs shift cost consciousness to the providers of services as much as to the payers. Medicare has developed a list of surgical procedures for which payment would be made when performed in ambulatory surgery centers (Appendix B). Some States use this list to guide their payment policies for outpatient surgical procedures, but many do not. Informational copies of Appendix B will be sent to the State Medicaid Directors with an explanatory transmittal letter.

REFERENCES

Carter, G.M., Jacobson, P.D., Kominski, G.F., and Perry, M.J.: "Use of DRGs by Non-Medicare Payers". Rand/UCLA/Harvard Center for Health Care Financing Policy Research, Project Memorandum, February 1994. Prepared for the Health Care Financing Administration under Master Contract 500-92-0023.

U.S. Department of Health and Human Services, Health Care Financing Administration, Medicaid Bureau: "Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 1993." Baltimore, MD.

GLOSSARY OF UTILIZATION MANAGEMENT METHODS

Ambulatory Surgery Program: A program that encourages or requires that specified surgical procedures be performed on an outpatient rather than inpatient basis. These include (1) programs that provide lists of surgical procedures that normally will not be covered if performed on an inpatient basis, (2) programs that offer financial incentives for providing specified surgical services in ambulatory settings.

Preadmission Testing Policy: A policy that directly encourages or requires preoperative testing in an outpatient rather than inpatient setting. (A DRG payment system would not be included in this definition.)

Same Day Admission Surgery Policy: A policy that directly encourages or requires that patients be admitted on the same day as their scheduled inpatient surgery.

Second Surgical Opinion Program: A program or policy that covers or requires one or more additional opinions when a physician recommends surgery.

Preadmission Certification Program: (Also known as prior authorization, preadmission screening, or preadmission review programs.) A program or policy that requires prior approval of hospital admissions. (Requirements under section 1902(a)(44) of the Social Security Act that the physician recommending the admission sign a statement that admission is warranted are not included.)

Lock-in Program: (Also known as recipient restriction.) A program that identifies recipients who have made inappropriate or excessive use of services, and assigns them to a single provider who supervises their care. These programs differ from high-cost case management programs because they target individuals believed to misuse services; high-cost case management programs attempt to reduce costs for expensive but appropriate care.

High-Cost Case Management Program: Programs that identify high-cost patients and facilitate the development and implementation of less costly appropriate courses of care. (These programs differ from lock-in programs because they focus on reducing costs for costly but appropriate care; lock-in programs target individuals believed to be misusing services.)

Primary Care Case Management Program: (Also known as a "gatekeeper" program.) A program that provides for or requires all nonemergency medical treatment for a recipient to be coordinated by a particular primary care provider. These operate

under section 1915(b) waivers.

Targeted Case Management Program: Program that covers or establishes case management (also known as case coordination) services for defined special populations; such as the disabled, pregnant women, or young children. The case managers work with clients directly to collect information on their health needs, and assist them in obtaining appropriate services.

Rebundling Activities: Utilization review to identify and correct the practice of unbundling of physician services. (Unbundling is defined as separate billing for procedures that should have been billed as one service.)

APPENDIX A

Report by Mathematica Policy Research, Inc.

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**AMBULATORY SURGERY, PREADMISSION
TESTING, AND SAME-DAY SURGERY:
STATE MEDICAID PROGRAMS' EXPERIENCE
AND FINDINGS FROM THE LITERATURE**

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EXECUTIVE SUMMARY

Dramatic increases in health care costs over the past two decades have drawn more attention to ways of implementing cost-containment measures. Ambulatory surgery, preadmission testing programs and same-day surgery are three such measures. In response to concerns about rising costs, and to better understand whether the Medicaid program should require these measures, the U.S. Congress requested a study (Section 4755(6)(3)(d) of OBRA-90). This report presents the results of the study, which was conducted by Mathematica Policy Research, Inc. under contract to the Health Care Financing Administration.

BACKGROUND

The three cost-containment measures explored in this report are utilization management efforts that attempt to reduce costs by shifting the locus of care from hospital inpatient departments to less costly outpatient settings. Ambulatory surgery programs encourage or require certain surgical procedures to be performed on an outpatient basis. Preadmission testing focuses on a requirement or incentive for preoperative tests to be performed on an outpatient basis. Same-day admission surgery policies directly encourage or require that patients be admitted on the day that their inpatient surgery is scheduled.

The purpose of this report is to (1) summarize the existing literature on the prevalence and characteristics of ambulatory surgery, preadmission testing, and same-day surgery programs; (2) analyze the impact of these measures on cost, quality, and access to care; and (3) present the results of a survey of state Medicaid agencies on these programs. We also explain where these programs fit in the context of the many other types of cost-containment efforts underway in the public and private sectors.

METHODOLOGY

To explore the impact of ambulatory surgery, preadmission testing and same-day surgery on Medicaid program costs, quality of care, and access to care for Medicaid beneficiaries, we performed a comprehensive literature review on these topics and conducted a mail survey of all state Medicaid agencies in July 1993 to identify both characteristics of existing cost-containment programs and state perceptions on program impact. To place these programs in the context of other cost-containment efforts, we also designed the survey to obtain information on seven other types of cost-containment programs and utilization review. The survey was structured with a screener to identify whether a program was in place. This was followed by brief questionnaires on each of the relevant existing programs. After extensive follow-up, 49 of the 51 state Medicaid agencies (96 percent) returned their surveys. Although we asked states to submit completed evaluations, we did not receive any for the three programs that are the focus of this report. Many of the evaluations we received on other programs were, for the most part, quickly prepared internal cost estimates, and only a few across all the programs used methodologies that could support firm conclusions about impact.

AMBULATORY SURGERY, PREADMISSION TESTING, AND SAME-DAY ADMISSION SURGERY, IN THE CONTEXT OF OTHER COST-CONTAINMENT EFFORTS

The full set of cost-containment efforts in the private sector includes cost-sharing, managed care systems such as HMOs, and wellness or health promotion programs in addition to programs that decrease hospital use such as the three examined in this study. To some extent, cost-containment efforts in state Medicaid programs mirror those in the private sector. However, the low-income status of the Medicaid population means that greater care must be taken that cost-containment programs do not reduce quality of or access to care. As a result, legal restrictions on cost-sharing and program requirements have helped to shape the managed care systems that may be used.

Of the 10 types of cost-containment efforts surveyed, the following 6 were frequently used in state Medicaid programs:

- *Lock-in Programs* (43 states). These identify recipients who have made inappropriate or excessive use of services and assign them to a single provider who supervises their care.
- *Targeted Case Management Programs* (41 states). These establish case management services for special populations such as pregnant women or young children.
- *Preadmission Certification Programs* (36 states). These require prior authorization of hospital admission by someone other than the physician recommending admission.
- *Primary Care Case Management Programs* (35 states). These provide for or require all nonemergency medical treatment for a Medicaid client to be coordinated by a particular primary care provider.
- *Ambulatory Surgery Programs* (32 states). These include two types of programs: those that list surgical procedures not normally covered if performed on an inpatient basis and those that offer financial incentives for providing specified surgical services in ambulatory settings.
- *Rebundling Activity* (27 states). This is utilization review that identifies and corrects the practice of separate billing ("unbundling") for procedures that should have been billed as one service.

Surveyed programs other than those listed above were far less prevalent than ambulatory surgery programs—the only one of the three programs of interest here that was frequently in place. Preadmission testing and same-day surgery programs were not used frequently (15 states or fewer), nor were two of the other types of programs on the survey—second surgical opinion programs and high-cost case management.

AMBULATORY SURGERY PROGRAMS

The number of ambulatory surgery programs in the public and private sectors grew dramatically during the 1980s, accompanying and stimulating a profound shift in site of care delivery. Beginning in the early 1980s, HCFA's Medicare rules encouraged ambulatory surgery by allowing 100 percent reimbursement of physician costs for ambulatory surgery rather than the 80 percent allowed for inpatient care (Ermann and Gabel 1985). Two surveys conducted in 1985 on cost-containment found that ambulatory surgery was the strategy most frequently implemented by surveyed firms (Hospitals 1985; Mercer-Meidinger 1985). Today, ambulatory surgery programs are in place in 65 percent of state Medicaid programs, with most first implemented during the 1980s. About two-thirds of the programs in place require, rather than encourage, specified procedures to be performed on an outpatient basis, although they generally allow exceptions to the requirement. Of the 17 states that do not have a program in place, only 3 plan to implement such a program in the future, and 10 believe that the costs of this type of program would exceed its benefits.

Impact on Cost

Several early studies concluded that ambulatory surgery programs or other efforts to shift the site of care from inpatient to outpatient settings reduce health care costs (*Same-Day Surgery* 1980; Cain 1985; Gilman 1984). A more recent study, however, suggests that the relationship between ambulatory surgery programs and cost savings is more tenuous. Pauly and Erder (1993) found that higher deductibles were more likely to consistently lower costs than were incentives to encourage ambulatory surgery; the substitution of outpatient for inpatient care that would create savings did not occur as expected with the incentives designed to promote ambulatory surgery.

Our survey found that 87 percent of the states with an ambulatory surgery program perceived that it had some or a strong beneficial effect on Medicaid costs. However, this result should be interpreted cautiously, since only 20 percent of states with such programs had evaluated them, and many of the evaluations were likely to have been quickly prepared internal cost estimates rather than methodologically sound analyses. Relative to several of the other programs in our survey, ambulatory surgery programs were viewed as being less effective in containing costs. That is, only 7 percent of states with these programs viewed it as strongly effective in cost reduction, compared to at least 32 percent of states that perceived the following four programs to be strongly effective: high-cost case management, lock-in programs, preadmission certification, and preadmission testing.

Impact on Quality of and Access to Care

The studies we reviewed concluded that shifting procedures from an inpatient to an outpatient setting has no adverse effect on the quality of care. In general, the studies found very low complication rates in ambulatory surgery centers (ASCs) and very little, if any, difference in those rates across ASCs, hospital-based ASCs, hospital outpatient departments, and the hospital inpatient setting (see, for example, Biswas and Leary 1992, DHHS 1990). Researchers also found that patients were generally more satisfied with the care they received in various outpatient settings than in the inpatient setting (DHHS 1989, Orkand 1977). However, these results should be interpreted cautiously since many of the existing studies were conducted before the large-scale shift from the inpatient to the ambulatory setting.

Our survey findings are consistent with the literature. That is, more than half of the states did not perceive that their program affected quality of care, while 40 percent reported some beneficial effect. None reported an adverse effect on quality.

No studies explicitly examined the effect of ambulatory surgery programs on access to care. Most studies on related topics asserted that ambulatory surgery increases access to care by (1) increasing the choices available to patients, (2) making surgery more convenient, and (3) lowering the cost of the procedures (not applicable for Medicaid clients) (Wolff and Dunniho 1982, Ermann and Gabel 1985). There is potential for access to care to be reduced for the Medicaid population to the extent that outpatients need more care and support in the home following surgery or to the extent that this population, compared to others, is less inclined to follow pre- or post-operative instructions. However, there is no evidence in the literature that these concerns are valid.

Again, our survey findings are consistent with the literature in that most states with ambulatory surgery programs (72 percent) perceived no significant effect on access to care, while 21 percent found some benefit to access. The remaining states perceived a strong benefit (7 percent).

PREADMISSION TESTING AND SAME-DAY ADMISSION SURGERY PROGRAMS

Preadmission testing and same-day admission surgery programs were first developed in the 1970s and became popular during the 1980s in the private and public sectors. The two programs have the same cost-reduction strategy—shifting the locus of care for routine diagnostic tests to outpatient settings, such as hospital ancillary departments, licensed laboratories, physicians' offices, and ambulatory surgery centers. We found no evidence in the literature on the frequency of in-hospital preoperative testing today. However, those we spoke with informally said that because of widespread changes in medical practice patterns during the 1980s, physicians rarely admit patients for preoperative testing regardless of whether a specific program is in place.

According to our survey, 11 state Medicaid programs have preadmission testing policies in place, and 15 have same-day admission surgery programs. Few additional states plan to add these programs (3 and 1, respectively). A significant number of states without such programs (12) thought that program costs would exceed benefits. Most states with these programs have general requirements for preadmission testing or same-day surgery; they do not target specific tests or surgeries.

Impact on Cost

The literature on the cost impact of same-day admission surgery and preadmission testing programs is scarce. Only two studies examined same-day admission surgery programs, and both found that the programs produced significant cost-savings. However, these studies were methodologically weak in ways likely to overstate the savings (Loop et al. 1983, Keithley et al. 1989). We found no studies that specifically examined the impact of preadmission testing programs on costs. The more general studies and follow-up telephone interviews on preadmission testing suggest that preadmission testing policies aimed at *reducing the number of tests* rather than changing the site of the tests is a promising strategy for reducing costs.

All state Medicaid agencies reported that their same-day surgery and preadmission testing policies had either some or a strong beneficial effect on costs. Those states with requirements rather

than programs to encourage same-day surgery or preadmission testing were more likely to cite a strong beneficial effect on cost. Although the number of states with these two programs was small, the proportion of states citing a strong cost benefit for preadmission testing programs was high relative to other programs (40 percent). This was not the case for same-day surgery, which was viewed as less effective than other programs.

Impact on Quality of and Access to Care

We found no direct evidence in the literature on the impact of preadmission testing or same-day surgery programs on quality of or access to care. These programs appear to be generally accepted, and access and quality were not even raised in the literature. We therefore conclude that they probably do not have an impact on quality of care or access to care.

Our survey findings support this tentative conclusion. A majority of states perceived their same-day admission surgery and preadmission testing programs to have no effect on quality of care, and about one-third in each case perceived that the program had some positive effect on quality. Nearly all states (89 percent or more) found the programs to have no effect on access to care. Only 9 and 15 percent of states with preadmission testing or same-day surgery programs, respectively, reported evaluating them.

CONCLUSIONS

On the basis of our study, we do not recommend that the Medicaid program require states to have ambulatory surgery, preadmission testing, and same-day surgery programs. Current research does not clearly show that these programs are effective, and even if presumed effective, they must be considered in the context of the many other cost-containment options available to states, including managed care options now being considered and implemented by states alone or in conjunction with a broader health reform strategy.

States perceive ambulatory surgery, preadmission testing programs, and same-day surgery programs to be less beneficial than many of the other cost-containment programs in our survey. Ambulatory surgery was the only one of the three that was frequently implemented, and states without programs in place showed little interest in implementing these three types of programs--many believed that program costs would outweigh benefits.

The absence of recent or methodologically sound research on these three types of programs means our literature review provided little help in drawing conclusions on the impact of these three programs. Although ambulatory surgery programs were most strongly supported in studies completed in the 1970s or early 1980s, the most recent study (Pauly and Erder 1993) casts doubt even on this finding. Yet despite the rather inconclusive nature of the research, ambulatory surgery, preadmission testing, and same-day surgery programs should still remain an option for states. We found nothing to suggest they have an adverse impact on access to care or quality of care, and many of the states that have implemented these programs report "some" benefit in terms of cost reduction.

I. INTRODUCTION

Health care costs have increased dramatically in the past two decades. Between 1970 and 1980, personal health care expenditures in the U.S., which represent private and public spending for direct health and medical services to individuals, increased by more than 200 percent. Between 1980 and 1989, those same expenditures increased at a lower but still rapid rate (Levit et al., 1991). These cost increases have been borne by all payers and have drawn more attention to ways of implementing cost-containment measures.

Ambulatory surgery, same-day admission surgery, and preadmission testing programs are three such measures. In response to concerns about rising costs, the U.S. Congress requested a study of these measures. This report presents the results of the study, which was conducted by Mathematica Policy Research, Inc. under contract with the Health Care Financing Administration.

A. METHODOLOGY

To explore the impact of ambulatory surgery, same-day surgery, and preadmission testing on program costs, quality of care, and access to care for Medicaid beneficiaries, we:

- Performed a comprehensive literature review on these topics
- Conducted a mail survey of all state Medicaid agencies to obtain their perceptions on program impact
- Collected and reviewed program evaluations identified by the state survey respondents.

The survey also identified procedures targeted by these programs, and identified characteristics of these programs that might be associated with program impact.

1. Literature Review

We found the literature on these measures through a combination of search and trace methods. We conducted a systematic on-line search using computerized databases, and we methodically searched through several printed sources. In addition, we traced references from the articles obtained through the systematic searches, and we contacted organizations and individuals who are familiar with the issues related to the cost-containment measures.

2. Survey Method

The survey of state Medicaid agencies on their cost-containment programs was developed and pilot tested in two states during Fall/Winter 1992-1993. Then, it was mailed to the Medicaid Director in 48 states and the District of Columbia in July 1993. The complete survey packet sent to each state Medicaid agency included eleven separate program-specific questionnaires. In addition to answering survey questions about their state's use of ambulatory surgery, preadmission testing, and same-day admission surgery policies, all Medicaid agencies were asked to answer comparable questions about the following additional cost-containment programs: second surgical opinion, preadmission certification, lock-in, high cost case management, primary care case management, targeted case management, and rebundling activity.¹ The three types of programs discussed here were defined for survey respondents as follows:

- **Ambulatory surgery program:** A program that encourages or requires that specified surgical procedures be performed on an outpatient rather than inpatient basis. These include (1) programs that provide lists of surgical procedures that normally will not be covered if performed on an outpatient basis, and (2) programs that offer financial incentives for providing specified surgical services in ambulatory settings.
- **Preadmission testing policy:** A policy that directly encourages or requires pre-operative testing in an outpatient rather than inpatient setting. (A DRG payment system would not be included in this definition.)

¹The results on these other programs are not relevant to this report except to provide context for the three types of efforts that are our focus here.

- *Same-day admission surgery*: A policy that directly encourages or requires that patients be admitted on the same day as their scheduled inpatient surgery.

Respondents were requested, in addition to completing the questionnaire, to provide any list of procedures targeted by these programs, and any program evaluation or cost impact estimates. After extensive followup, the survey team received responses from 49 of the 51 Medicaid agencies (96 percent response rate). Because a few states who returned the survey packet did not respond to program-specific questions on one or more programs they had in place, the program-specific information response rates for the three programs covered in this report were: 97 percent for ambulatory surgery programs, 100 percent for preadmission testing policies, and 93 percent for same-day admission surgery policies. So, for example, 97 percent of the states reporting ambulatory surgery programs in place returned the questionnaire for that program.

B. REPORT ORGANIZATION

Chapter II discusses how ambulatory surgery, preadmission testing, and same-day surgery admission programs fit into the broader group of cost-containment efforts in the private and public sectors. Chapter III focuses on ambulatory surgery programs, and Chapter IV covers same-day admission surgery and preadmission testing programs. For each cost-containment measure, we present its underlying assumptions and prevalence, we discuss what the literature shows about its impact on health care costs, quality of care, and access to care, and we report our survey findings.

II. AMBULATORY SURGERY, SAME-DAY ADMISSION SURGERY, AND PREADMISSION TESTING PROGRAMS IN THE CONTEXT OF OTHER COST-CONTAINMENT EFFORTS

Ambulatory surgery, same-day admission surgery, and preadmission testing are three cost-containment measures designed to reduce the unnecessary use of hospital inpatient services. The following discussion considers how these measures fit into the broader group of cost-containment efforts in the private and public sectors. Although cost-containment efforts can include direct cost-cutting through the reduction of benefits or the capping of benefit payments, we are concerned primarily with efforts designed to reduce costs by influencing service utilization patterns.

A. COST-CONTAINMENT MEASURES IN THE PRIVATE SECTOR

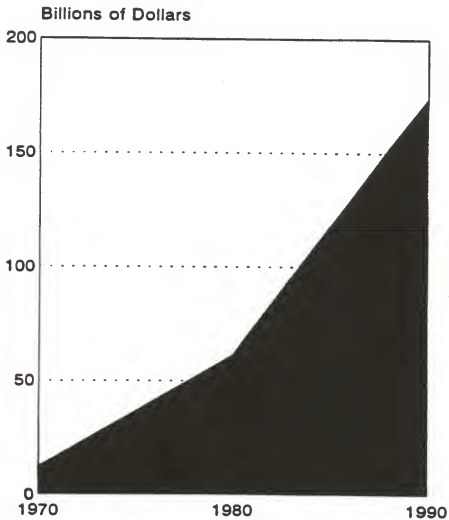
Figure II.1 shows the increases in private health insurance expenditures by employers between 1970 and 1990. Between 1984 and 1991, the average annual health plan cost per employee increased from \$1,645 to \$3,605 (A. Foster Higgins and Company, 1991). These rising costs prompted more interest on the part of employers to control health care expenditures. Since benefit payments account for more than 90 percent of the premium dollar for most large group health insurance coverage, employers have generally focused cost-containment efforts on controlling these payments. This strategy attempts to alter the incentives for patients and providers to control costs through the following: increased cost-sharing, decreased hospital use, alternative health care delivery systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and wellness, or health promotion, programs [Fox, 1984; Employee Benefits Research Institute (EBRI), 1992].

1. Increased Cost-Sharing

Increased cost-sharing reduces employer health insurance costs by shifting some of the costs from the employer to the employees and by creating incentives for employees to decrease utilization

FIGURE II.1

GROWTH IN PRIVATE HEALTH INSURANCE EXPENDITURES BY EMPLOYERS



Source: A.Foster Higgins & Company, Inc. Health Care Benefits Survey, Report 1-Indemnity Plans: Cost, Design and Funding, 1991. Princeton, NJ: A.Foster Higgins & Company, Inc.

by raising their out-of-pocket expenses (Fox, 1984). Higher deductibles have been one popular mechanism for reducing employer costs. For example, in medium and large firms, the percentage of full-time employees who had deductibles of \$150 or more increased from less than 10 percent in 1980 to more than 50 percent in 1989 (U.S. Department of Labor, 1981 and 1990).

2. Decreased Hospital Use

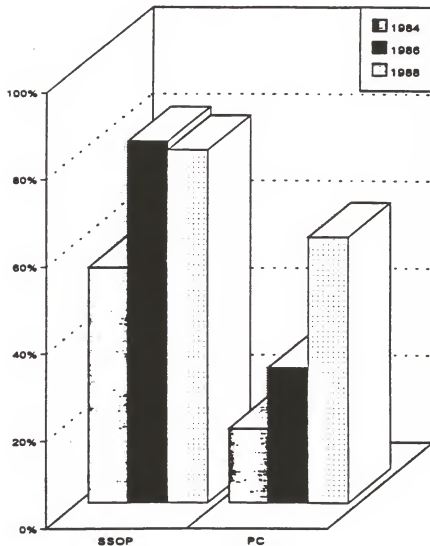
Hospital services are the single largest component of personal health care costs, accounting for more than 40 percent of total personal health care costs each year. Between 1960 and 1970, hospital services increased from 39 percent of personal health care expenses to 43 percent (Levit et al., 1991). During the 1980s, cost-containment efforts of private and public insurers focused on hospital care spending. Concurrently, the rate of growth of hospital spending slowed: the percentage of personal health care cost composed of hospital services decreased from 47 percent in 1980 to 44 percent in 1990 (Levit et al., 1991). Measures to decrease hospital use include curbing excessive utilization and shifting the focus of care from the more expensive hospital inpatient setting to the less expensive ambulatory setting.

Initiatives to curb excessive hospital utilization include second surgical opinion programs and preadmission certification programs. A 1990 survey of more than 1,900 companies of all sizes found that 81 percent of plans required preadmission certification (A. Foster Higgins and Company, 1990). A 1984 survey of 1,185 companies of all sizes found that 26 percent of the companies that responded conducted hospital preadmission reviews, compared with only two percent in 1982 (Hewitt Associates, 1984). For 170 employers, Figure II.2 shows the growth in the use of second surgical opinion and preadmission certification programs for hospital stays between 1984 and 1986.

Initiatives to shift the locus of care include ambulatory surgery programs, preadmission testing programs, and same-day admission surgery programs. A 1985 survey of the CEOs of the nation's 5,000 largest employers found that 71 percent of the companies that responded encouraged the use of ambulatory surgery facilities (Mercer-Meidinger, Inc. 1985). In 1984, 1986, and 1988, The Wyatt

FIGURE IL2

**GROWTH IN SECOND SURGICAL OPINION PROGRAMS (SSOP)
PREADMISSION CERTIFICATION (PC) FOR HOSPITAL STAYS
(170 employers)**



Source: The Wyatt Company, Group Benefits Survey 1984, 1986, and 1988. Washington, DC. The Wyatt Company.

Company's Group Benefits Survey found that preadmission testing and the use of ambulatory surgical facilities were among the most prevalent cost-containment measures adopted by the core group of 170 employers surveyed.

3. Alternative Health Care Delivery Systems

Alternative health care delivery systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have become increasingly popular among employers and employees. Broadly referred to as managed care systems, they are designed to eliminate duplicate, inappropriate, or unnecessary services through mechanisms that monitor and review treatment decisions. Between 1986 and 1990, the percentage of employers surveyed by the A. Foster Higgins Health Care Benefits Survey who offered HMO options to their employees increased from 54 percent to 63 percent, while the percentage offering PPO options increased from 15 percent to 32 percent (A. Foster Higgins and Company, 1986 and 1990).

4. Wellness Programs

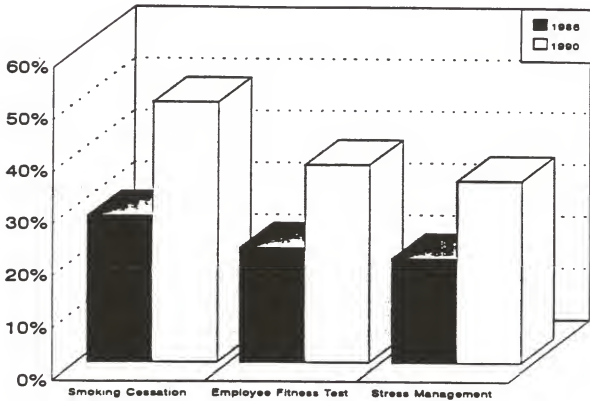
Wellness, or health promotion, programs encourage participants to adopt healthy lifestyles. These programs are based on the assumption that healthy people use the health care system less frequently and/or in a less costly manner. Such programs have become popular as employers have begun to recognize that assisting employees in maintaining good health may play a large role in reducing health care costs (Health Insurance Association of America, 1990). Figure II.3, shows the growth in the percentage of employers offering selected wellness, or health promotion, programs.

B. COST CONTAINMENT MEASURES IN THE PUBLIC SECTOR: THE MEDICAID PROGRAM

Medicaid program costs, which increased dramatically during the 1970s and 1980s, continue to grow rapidly. Total federal and state program costs for Medicaid have more than doubled since 1987, rising from \$49 billion in fiscal year 1987 to an estimated \$118.2 billion in fiscal year 1992

FIGURE II.3

GROWTH IN PERCENTAGE OF EMPLOYERS OFFERING
WELLNESS, OR HEALTH PROMOTION, PROGRAMS



Source: The Wyatt Company, Group Benefits Survey 1990.
Washington, DC: The Wyatt Company.

(DHHS, 1993). The Health Care Financing Administration also projects a 12.6 percent rate of additional program growth between 1992 and 1998 (DHHS, 1993). To address the problem posed by these rising costs, many state Medicaid programs have implemented cost-containment measures similar to some of those found in the private sector. By 1984, ambulatory surgery programs had been implemented in over a dozen state Medicaid programs, and by 1986, 32 state Medicaid programs had limited the number of covered hospital days, implemented a preadmission review program, or implemented a mandatory second surgical opinion program (National Governors' Association, 1984; Health Care Financing Administration, 1990). State Medicaid agencies have also implemented other types of cost-containment programs that focus on reducing hospital expenditures, including, pre-admission certification and rebundling activities. Some state Medicaid agencies have also turned to cost-containment programs such as primary care case management, targeted case management, high cost case management, and lock-in arrangements that mirror the alternative health care delivery efforts of the private sector. However, some measures suited to the private sector may not be applicable to the public sector because of conditions unique to the Medicaid program. More specifically, cost-containment measures implemented by state Medicaid agencies must respond to challenges posed by (1) the low-income status of Medicaid beneficiaries; (2) the effects of those measures on the supply of participating providers; and, (3) the legal and administrative framework of the Medicaid program.

Table II.1 shows the prevalence of the ten types of cost-containment efforts included in our survey of state Medicaid agencies. Of these, the following were frequently used:

- *Lock-in Programs* (43 states). These identify recipients who have made inappropriate or excessive use of services, and assign them to a single provider who supervises their care.
- *Targeted Case Management Programs* (41 states). These establish case management services for defined special populations such as pregnant women or young children.

TABLE II.1
NUMBER OF STATE MEDICAID AGENCIES WITH TEN TYPES
OF COST-CONTAINMENT MEASURES

Type of Program	Number of States
Ambulatory Surgery Program	32
Preadmission Testing Policy	11
Same-day Admission Surgery Policy	15
Second Surgical Opinion Program	10
Preadmission Certification Program	36
Lock-in Program	43
High Cost Case Management Program	13
Primary Care Case Management Program	35
Targeted Case Management Program	41
Rebundling Activity	27

- **Preadmission Certification Programs** (36 states). These require prior authorization of hospital admission by someone other than the physician recommending admission.
- **Primary Care Case Management Programs** (35 states). These provide for or require all nonemergency medical treatment for a Medicaid client be coordinated by a particular primary care provider.
- **Ambulatory Surgery Programs** (32 states). These include (1) programs that provide lists of surgical procedures that normally will not be covered if performed on an inpatient basis, and (2) programs that offer financial incentives for providing specified surgical services in ambulatory settings.
- **Rebundling Activity** (27 states). This was utilization review to identify and correct the practice of separate billing ("unbundling") for procedures that should have been billed as one service.

The other programs surveyed were far less frequently used, including two of the three programs of interest here (16 states or fewer). These were preadmission testing policies, same-day admission surgery policies, second surgical opinion programs, and high-cost case management programs.

Because of the low-income status of Medicaid beneficiaries, the financial incentives commonly used in the private sector to contain costs, such as increased cost-sharing, have the potential to more strongly affect Medicaid beneficiaries' access to care. For this reason, Medicaid copayments are tightly restricted by law. Cost-containment efforts that reduce payments to providers or increase the administrative burden on providers have the potential to reduce the already low number of physicians in certain areas who accept Medicaid patients, thus further reducing access to care. Finally, cost-containment measures within Medicaid must be structured within Medicaid's legal and administrative framework. For example, state Medicaid programs must continue to cover all mandatory services and may require only limited copayments for specified services.

III. AMBULATORY SURGERY PROGRAMS

A. OVERVIEW

The number of procedures that can safely be performed on an ambulatory basis has increased dramatically in the past decade with advances in medical science and technology. For such procedures, the patient is admitted to, treated at, and expected to leave the facility on the same day (Detmer 1981). The decision about which procedures to target for such programs must consider both the potential cost-savings and the need to maintain access to necessary inpatient care. The initial shift of procedures from the inpatient to the outpatient setting was made possible by the following factors: (1) the development of anesthetics that act rapidly, leaving few prolonged side effects such as drowsiness and transient nausea; (2) the use of short-acting narcotic and non-narcotic analgesics to treat pain, and drugs to manage nausea and vomiting, thus reducing patient discomfort after surgery; and (3) physicians who encourage their patients to become ambulatory soon after surgery, leading to decreased recovery time (Burns and Ferber 1981). The widespread use of more sophisticated techniques such as endoscopy and laser operations has also contributed to the burgeoning number of procedures that are performed in an outpatient setting (American College of Surgeons 1988).

Ambulatory surgery programs attempt to control costs by encouraging or requiring specified surgical procedures to be performed on an outpatient, rather than an inpatient basis. Programs that *encourage* specified procedures to be performed on an outpatient basis do so by giving providers financial incentives to perform these procedures in an ambulatory setting. These financial incentives may include paying the physician more than the usual and customary reimbursement level for specific procedures if performed on an outpatient basis, or paying the physician less than the usual and customary charges for specific procedures if performed on an inpatient basis. Financial incentives may also be offered to the patients in the form of lower deductibles or coinsurance (Fox

1984). Programs that *require* the specified procedures to be performed in the outpatient setting list procedures not covered by the health plan if performed on an inpatient basis. However, such programs normally include an exceptions process that would allow surgeons to perform those procedures in the inpatient setting if medically necessary.

Ambulatory surgery programs may also dictate the outpatient setting in which the specified procedures are to be performed through the use of payment policies that cover ambulatory surgery performed in one setting but not another. Ambulatory surgery can be performed in three settings--the outpatient department of a hospital, an ambulatory surgical center affiliated with the hospital, or a free-standing ambulatory surgical center (ASC).¹ The number of outpatient facilities has grown. In 1984, there were 238 operational ASCs (Ermann and Gabel 1985). This grew to 1,422 in 1990, and to 1,722 by December 1993 (Henderson 1991; telephone interview, Stacey Meyers, SMG, January 24, 1994). Procedures in ambulatory settings have increased dramatically as well. For example, procedures in ASCs increased from 0.3 million in 1984 to 2.6 million in 1990 (Ermann and Gabel 1985; Henderson 1991). This growth resulted in large increases in dollars spent for outpatient care. National spending for hospital outpatient procedures, for example, grew from \$13.5 billion in 1981 to \$63 billion in 1991 (Letsch et al. 1992).

B. BACKGROUND AND FINDINGS FROM THE LITERATURE

Two assumptions underlie ambulatory surgery programs:

1. Outpatient settings are less expensive than inpatient settings for the same procedure

¹Under most health plans, the physician's fee is covered regardless of the location in which the ambulatory surgical procedure is performed. The facility fee, however, is not always covered for all settings (Fox, 1984). Medicare, for example, does not cover ambulatory surgical procedures performed in each of the three settings. Medicare will pay the facility fee for all ambulatory surgical procedures performed in hospital outpatient departments or hospital-affiliated ASCs but will only reimburse Medicare-certified ASCs for a list of specific procedures, (Gail Durant, Executive Director, Federated Ambulatory Surgery Association, telephone interview, October 15, 1992.)

2. Shifting procedures to the outpatient setting will result in a concomitant decrease in the number of inpatient admissions for the same procedures

Several factors could contribute to the lower per-case cost of ambulatory settings. First, ambulatory surgery eliminates overnight hospital stays. In the mid-1980s, researchers found that ambulatory surgery saved the costs of an average of one to three days of hospitalization (Ermann and Gabel 1985). Second, charges for ancillary services may be lower in outpatient settings because indirect costs such as overhead are higher in a hospital, which must maintain more expensive equipment and greater capacity than in an ambulatory surgical center.

Despite this per-case cost advantage, some cost increases may offset these swings if the shift toward ambulatory surgery increases the total volume of procedures (Evans and Robinson 1980; Fox 1984). For example, the development of arthroscopic knee surgery made it possible to shift knee surgery to the outpatient setting. It also reduced the morbidity and lost work time associated with knee surgery. Along with increased patient awareness of sports health, shifting knee surgery to the outpatient setting contributed to the increase in the number of procedures performed (Pruzansky et al. 1989).

1. Trends in the Prevalence of Ambulatory Surgery Programs and Procedures

The number of ambulatory surgery programs grew dramatically during the 1980s, accompanying and stimulating the profound shift in site of care. Early efforts to encourage the shift were undertaken in both the private and public sectors. In January 1981, for example, the Blue Cross and Blue Shield Association issued a policy statement to member plans recommending that surgery be performed in the "least cost manner enabling delivery of safe high-quality care" and encouraging the "appropriate growth of ambulatory surgery and more selective use of inpatient care for surgery" (Ermann and Gabel 1985). At about the same time, the Health Care Financing Administration developed new rules for Medicare designed to encourage ambulatory surgery. Instead of the 80

percent allowed for inpatient care, Medicare began to allow 100 percent reimbursement of physician costs for ambulatory surgery (Ermann and Gabel 1985).

We found no surveys or studies that explicitly looked at the implementation of ambulatory surgery programs, although several surveys during the 1980s showed an increasing number of employers encouraging the shift to ambulatory surgery. Two surveys conducted in 1985 found ambulatory surgery to be the most frequently implemented cost-containment strategy among the surveyed firms, with 82 percent of the employers in one survey and 71 percent of the employers in the other using ambulatory surgery (Hospitals 1985; Mercer-Meidinger 1985). Many employers provided financial incentives to employees to encourage outpatient surgery: one survey found that 50 percent of employers required no coinsurance for outpatient surgical care, while only 29 percent of them required no coinsurance for inpatient surgical care (A. Foster Higgins 1988).

Ambulatory surgery is widely accepted now. The dramatic shift in site of care for many surgical procedures has changed the practice patterns of providers. Certain surgical procedures are so commonly performed in ambulatory settings that neither physicians nor hospitals would admit patients for such procedures, except under very unusual circumstances Sally Bleeks, Manager of Utilization Management, Blue Cross/Blue Shield Association, telephone interview, October 23, 1992. The change in practice patterns may explain the reduction in the percentage of employers requiring no coinsurance for outpatient surgical care from 50 percent in 1988 to 36 percent in 1990 as employers determine that incentives are no longer needed to encourage the use of ambulatory surgery (A. Foster Higgins and Company 1988 and 1990).

2. Procedures Covered by Ambulatory Surgery Programs

Twenty to 40 percent of inpatient surgical procedures could be performed on an outpatient basis, according to a number of the studies that we found (Ermann and Gabel 1985; Detmer 1981; Lairson et al. 1980). These figures may not reflect the percentage of surgeries still performed in the inpatient setting today, however, since they come from a 1972 article, prior to the dramatic shift in

place of care to the outpatient setting during the 1980s. Despite the age of the numbers, there is general consensus in the literature that many surgical procedures are safely performed in the outpatient setting, although there is no universal list of surgical procedures that are required by every plan to be performed on an ambulatory basis. Each health plan has its own list that may differ from the lists of other plans. For example, each Blue Cross and Blue Shield plan determines its own list of procedures covered or required for payment under ambulatory surgery programs. Procedures common to many, if not most, Blue Cross and Blue Shield lists include: dilation and curettage, tubal ligation, tonsillectomy, and bunionectomy (Sally Bleeks, telephone interview, October 23, 1992).

The variation across plans in the procedures required to be performed in an outpatient setting may reflect the different criteria plans use to determine which procedures to include in the list, regional differences in physician use of sophisticated techniques, and differences in plan demographics. Ambulatory surgery patients must be carefully selected by a physician. The American College of Surgeons (1988) stresses that in determining who is suitable for ambulatory surgery, the physician should consider anesthetic risk, age, and general medical condition of the patient; the expected duration and complexity of the operation; the anticipated degree and duration of postoperative pain and discomfort; and the probability of postoperative complications. Different plan demographics would be expected to result in slightly different lists of procedures for different plans. To the extent that Medicaid beneficiaries are generally younger or older, and often sicker than the rest of the U.S. population, the procedures appropriate for a list for Medicaid beneficiaries would be affected (Wilensky and Berk 1982).

3. Impact on Health Care Costs

Our literature review provided no definitive conclusion about the impact of ambulatory surgery programs on health care costs. While all but one of the studies we examined found cost-savings from performing surgery in outpatient settings compared with performing the same procedures in inpatient settings, the studies that reported cost-savings were old, having been conducted in the late

1970s and early 1980s, and most had methodological weaknesses. As a result, they were likely to have overstated the potential savings associated with ambulatory surgery.

a. Evidence from the Review

We found two studies that explicitly examined cost-savings from ambulatory surgery programs. Both concluded that such programs reduced health care costs (Same-Day Surgery 1980; Cain 1985). Four studies compared the costs of performing certain procedures in inpatient settings with the costs of performing the same procedures in outpatient settings. These studies also concluded that the shift in procedures would generate cost savings (Same-Day Surgery 1980; Evans 1980; Lairson et al. 1980; Gilman 1984). Finally, we found two studies that compared costs in different outpatient settings. These two studies also concluded that outpatient settings were less expensive than inpatient settings for the same procedures, and they also found that costs differed from one outpatient setting to the next. (Orkand Corp. 1977; Wolff and Dunnihoo 1982). Table III.1 summarizes each study.

Results from a recent study, however, suggest a more tenuous relationship between ambulatory surgery programs and increased cost savings. Authors of the 1993 study, which examined whether insurance policy arrangements intended to encourage ambulatory surgery cause changes in the site of surgery and result in lower total costs, concluded that lower insurance coverage deductibles for ambulatory surgery relative to that for inpatient surgery will not consistently lower cost because no appreciable net substitution occurs between surgery sites. Higher deductibles, they found, were more likely to consistently lower costs than were incentives to encourage ambulatory surgery (Pauly and Erder 1993).

b. Limitations of the Evidence

Our evidence is limited by two factors: (1) the age of most of the studies and (2) methodological weaknesses in the studies. Both limitations may cause the studies to overstate the cost savings

TABLE III.1
SUMMARY OF STUDIES

Author	Year	Study Design/Content	Key Findings Related to Impact on Health Care Costs
Studies That Examined Ambulatory Surgery Programs			
CIGNA	1983	Estimated cost-savings based on 1983 statistics on ambulatory surgery programs in CIGNA plans.	- Estimated savings between one and two percent of premiums. - Actual percentage varies according to geographic area and plan design.
National Capital Medical Foundation	1981	Studied the effects on costs of requiring 49 surgical procedures be performed on an outpatient basis in order for physicians to receive Medicaid or Medicare reimbursement.	Estimated savings of \$600,000.
Studies That Compared the Costs of Performing Certain Procedures in Inpatient Settings with the Costs of Performing the Same Procedures in Outpatient Settings			
Johns Hopkins	1983	Examined the effects of cost-containment activities of Blue Cross/Blue Shield.	Procedures performed on an outpatient basis saved an average of 45 percent of the cost of performing the same procedure on a patient admitted to a hospital for an overnight stay.
Evans	1980 (study period was 1975)	Retrospective study of children who had surgery performed at a specific hospital during 1975. Compared the costs of 460 patients who had surgery performed on an inpatient basis in 1975 but who were judged to be eligible for outpatient surgery with the costs of 2169 patients who had their surgeries performed on an outpatient basis during the same period.	Savings of approximately \$339 per procedure performed on an outpatient basis, compared with the same procedure performed in an inpatient setting.
Lairson et al.	1980	Retrospective study of 446 randomly selected patients who underwent either dilation and curettage, or excision of skin lesions between 1967 and 19764. The authors developed a choice model to predict the mode of surgery, and used the model to make estimates of cost-savings. They also compared the cost-savings estimated under the choice model with cost-savings obtained by applying the simple proportions of ambulatory surgery cases in the base year to cases in 1974.	- Under the choice model, estimated savings of about \$250 per case for dilation and curettage, and about \$340 per case for excision of skin lesions. - Estimates obtained using proportions and mean length of stay were about 19 percent higher for dilation and curettage, and more than 100 percent higher for excision of skin lesions.
Kaiser Permanente Medical Care Program	1979	NA	- If ambulatory surgery increased from 10 percent to 30 percent of all surgical procedures, almost \$774 million would be saved nationally each year. - Average cost-savings per patient were approximately \$192.

Table III.1 (continued)

Author	Year	Study Design/Content	Key Findings Related to Impact on Health Care Costs
Studies That Compared Costs of ASCs With Hospital Inpatient and Hospital Outpatient Department or Hospital Ambulatory Units			
Wolff and Dunnahoo	1982 (study period between 1978 and 1981)	Study of 5,369 patients who had surgical procedures performed at a freestanding ambulatory surgical center between 1978 and 1981.	• Per case charges for dilation and curettage were approximately twice as high when performed inpatient compared with the ASC. • Per case charge differences for dilation and curettage between a local ambulatory hospital unit and the ASC were about 15 percent in 1978 but increased to about 50 percent in 1981. • Per case charges for laparoscopy were more than 30 percent higher in the hospital inpatient unit compared with the ASC in 1978. That difference increased to more than 60 percent in 1981. • Per case charges for laparoscopy were more than 30 percent higher in a hospital-based ambulatory unit compared with the ASC in 1978. That difference increased to more than 0 percent in 1981.
Orland Corp.	1977	Prospective study of approximately 900 patients who had surgeries performed in one of seven institutions in the Phoenix, AZ area. The study focused on 12 procedures.	• ASCs had lower average total costs for four out of five procedures when compared with hospital inpatient departments, with differences ranging from a low of 18.6 percent for one procedure to 38.7 percent for another. • ASCs had lower average total costs for ten out of eleven procedures compared with hospital-based ambulatory surgery centers, with differences ranging from a low of 2.8 percent, to a high of 23.6 percent. • ASCs had lower average total costs for all three procedures compared with hospital inpatient settings, with differences in costs ranging from 2.5 percent to 12.2 percent.

NA: not available.

associated with ambulatory surgery programs. Old studies may overstate the savings that could be achieved through similar programs today for two reasons:

- The difference between hospital inpatient costs and costs in outpatient settings have decreased over the years due to the increasing cost-containment pressures on hospitals (Sally Bleeks, telephone interview, October 23, 1992).
- Many of the surgical procedures examined in those studies have already been shifted to the outpatient setting. As this trend continues, the procedures that remain are likely to be more difficult and more costly to shift to the outpatient setting because of, for example, the complexity of the procedure and the condition of the patients.

Methodologically weak studies tend to overstate cost savings for several reasons:

- *Lack of control for severity of illness.* The studies did not control for severity of illness in comparing the costs for patients who had ambulatory surgery to costs for patients who had the same procedures performed in an inpatient setting. As a result, the studies would tend to overestimate the savings achievable through mandatory ambulatory surgery programs if there were systematic differences between those two groups of patients. There is reason to believe that such differences existed. The studies were conducted before ambulatory surgery programs became very common. The patients selected for ambulatory surgery would have been those least likely to develop complications when having the surgery performed in an outpatient setting. Those patients who were more likely to develop complications would have had the procedures performed in the inpatient setting.
- *Longitudinal method without control group.* Several studies selected a base period and used patients admitted to a hospital during the base period as the comparison group to compare the differences in costs from having certain procedures performed in an outpatient setting rather than an inpatient setting. Such studies generally assumed that all of the patients who had the selected procedure performed in the inpatient setting during the base period would have had the same procedure performed in the outpatient setting during the study period. Lairson et al (1980) developed a model to predict the surgeon's choice between an inpatient setting and an outpatient setting for two procedures: dilation and curettage, and excision of skin lesions. They found that assuming that all dilation and curettages performed in a hospital in the base year would be performed in the outpatient setting during the study period produced estimates of cost-savings that were 19 percent higher than the estimates produced using their choice model. They also found that assuming that all excisions of skin lesions performed in a hospital in the base year would be performed in the outpatient setting during the study period produced estimates of cost-savings that were more than 100 percent higher than the estimates produced using their choice model.

4. Impact on Quality of Care and Access to Health Care

a. Quality of Care

The studies we reviewed concluded that shifting procedures from an inpatient to an ambulatory setting has no adverse effect on the quality of care. These studies reviewed quality of care in terms of the rate of complications in various settings and/or patients' satisfaction with the care they received in different settings and/or patients' satisfaction with the care they received in different settings. In general, the studies found very low complication rates in ASCs and very little, if any, difference in those rates across ASCs, hospital-based ASCs, hospital outpatient departments, and hospital inpatient departments. Study researchers also found that patients were generally more satisfied with the care they received in the various outpatient settings than in the hospital inpatient setting. Patients were also, on average, more satisfied with the care they received in ASCs than in the other outpatient settings. Table III.2 lists the studies that examined the rate of complications from ambulatory surgery. Table III.3 lists the studies that included measurements of patient satisfaction.

Again, the results of these studies on quality of care should be interpreted with caution. Many of the cited studies are old, having been conducted prior to the mid-1980s and the large scale shifting of procedures to the ambulatory setting.

To the extent that surgical techniques and technology are more advanced today and surgeons are more experienced and skilled in performing the specified procedures on an outpatient basis, quality of care may be improved. To the extent that more difficult procedures are increasingly being shifted to the outpatient setting, quality of care may worsen.

Successful outcomes from ambulatory surgery require patient adherence to preoperative and postoperative instructions (Driscoll 1986; Koska 1988). To the extent that Medicaid beneficiaries have trouble understanding and following such instructions, quality of care may be adversely affected (Koska 1988).

TABLE III.2

STUDIES THAT EXAMINED RATE OF COMPLICATIONS IN AMBULATORY SURGERY

Author	Year	Study Design	Key Findings Related to Rate of Complications
Itiswas and Leary	1992 (study period between 1984 and 1990)	A retrospective study of postoperative hospital admissions from a day surgery unit in Australia. Medical records of those who required hospitalization were reviewed to determine the cause of the admission.	• There were only 225 admissions out of a total of 18,321 procedures performed - a complication rate of 1.2 percent.
U.S. Department of Health and Human Services, Office of the Inspector General	1990	Survey of a random sample of 1,170 Medicare beneficiaries in 11 states who had one of 4 outpatient surgical procedures performed in the period between January and March 1988. The procedures were cataract extraction with intraocular lens implant, upper gastrointestinal endoscopy, colonoscopy, and bunionectomy. Half of the sample had the procedures performed in hospital outpatient departments. The other half had the procedures performed in ASCs.	• Approximately 14 percent of the survey respondents whose surgeries were documented received poor or questionable care. • ASCs had more cases of poor and questionable care but the difference was not statistically significant. • The overall hospital outpatient department complication rate was twice the complication rate of the ASCs. That difference was statistically significant.
U.S. Department of Health and Human Services, Office of the Inspector General	1989	Same survey as above.	• Approximately 90 percent of respondents reported no complications.
Wolff and Dunnihoo	1982 (study period between 1978 and 1981)	Study of 5,369 patients who had surgical procedures performed at a free-standing ambulatory surgical center between 1978 and 1981. Infection rates were determined by having a nurse call the offices of the physicians who performed that surgery on a weekly basis.	• There were two hospital transfers - a transfer rate of 0.04 percent. • Three superficial wound infections were discovered - an infection rate of 0.06 percent.
Burns	1981	Retrospective study of 76,581 procedures that the Free-Standing Ambulatory Surgery Association reported performed in 1980.	• Found 10,767 complications were found - a complication rate of 14.1 percent. • If nausea and vomiting were omitted, the complication rate fell to 5.4 percent. • A total of 223 patients required hospitalization following surgery - a hospitalization rate of 2.1 percent. • Eight patients had emergency or life-threatening complications.

Table III.2 (continued)

Author	Year	Study Design	Key Findings Related to Rate of Complications
Natof	1980 (study period between 1974 and 1978)	Prospective study of 13,433 patients in a free-standing ASC who had surgeries performed between 1974 and 1978. The study explicitly excludes transient nausea, vomiting, dizziness, sore throat, weakness, and headache as complications.	• 106 complications were found - a complication rate of 0.8 percent.
Orkand Corp.	1977	Prospective study of approximately 900 patients who had surgeries performed in one of seven institutions in the Phoenix, AZ area. The study focused on 12 procedures.	• There were a very small number of hospital transfers from the free-standing ASC. • There was no incidence of six specific types of complications. • The ASC had a relatively higher proportion of patients with nausea, vomiting, and pain than did the other settings.
Shields	1969	Reports on the author's 5-year experience with hospital outpatient surgery programs for 175 patients who had gynecologic surgical procedures performed in a hospital outpatient department between 1962 and 1967.	• Only five patients required hospitalizations - a complication rate of about 2.9 percent.

TABLE III.3

STUDIES THAT EXAMINED SATISFACTION

Author	Year	Study Design	Key Findings Related to Patient Satisfaction
Orkaad Corp.	1977	Prospective study of approximately 900 patients who had surgeries performed in one of seven institutions in the Phoenix, AZ area. The study focused on 12 procedures.	• Very little difference between the hospital ambulatory surgical center and the ASC with respect to patient satisfaction. • A greater percentage of negative comments from hospital outpatient department patients than from patients who had their procedures performed in any of the other three settings.
U.S. Department of Health and Human Services, Office of the Inspector General	1989	Survey of a random sample of 1,170 Medicare beneficiaries in 11 states who had one of 4 outpatient surgical procedures performed in the period between January and March 1988. The procedures were cataract extraction with intracocular lens implant, upper gastrointestinal endoscopy, colonoscopy, and bunionectomy. Half the sample had the procedures performed in hospital outpatient departments. The other half had the procedures performed in ASCs.	• The majority of the respondents to the survey preferred outpatient surgery to an inpatient hospital stay for the same procedure regardless of age, sex, or whether they had the procedure performed in the hospital outpatient department or the ASC. • 91 percent of those who had undergone cataract surgery and 83 percent of those who had undergone bunionectomies preferred the outpatient setting to the inpatient setting.

b. Access to Care

We found no studies that explicitly looked at access to care relative to ambulatory surgery programs. Most studies that examined either the cost-savings of ambulatory surgery or the effects of ambulatory surgery on quality of care assert that ambulatory surgery increases access to care by (1) increasing the choices available to patients, (2) making surgery more convenient as a result of the shorter periods that patients have to be away from home and work, and (3) lowering the cost of the procedures (Wolff and Dunnihoo 1982; Ermann and Gabel 1985).

Concerns about access to care are especially pertinent to the Medicaid population. First, Medicaid beneficiaries are generally in poorer health and may therefore be more likely to develop complications in ambulatory surgical settings than the general population. As a result, the need for the surgeon to obtain authorization to perform certain procedures in the inpatient setting may create a barrier to access. The potential for, or the extent of, this "barrier" depends on the degree of difficulty involved in obtaining such a determination.

Second, the need for patients to follow preoperative and postoperative instructions and the need for postoperative care and support by family members after ambulatory surgery may also affect access for Medicaid patients. Patients who do not follow preoperative instructions (often because they may not understand them), may have their surgery postponed. Patients also often require care and support from family members or other caregivers in the home after ambulatory surgery. To the extent that people are not available to help with postoperative care in the home, access would also be affected. However, anticipating these kinds of access problems, physicians may request medical necessity exceptions to perform the procedure in an inpatient setting, thus reducing the potential for barriers to access. We did not find any evidence on how often either of these situations occur.

C. MEDICAID SURVEY RESULTS ON AMBULATORY SURGERY PROGRAMS

Of the three cost-containment approaches considered in this report, state Medicaid agencies were most likely to implement ambulatory surgery programs. We found that the majority of states

with ambulatory surgery programs were likely to consider their programs to have some positive impact on Medicaid costs and on access to health care. Fewer states were convinced that the program improved quality of care, although no state reported that program implementation had reduced the quality of care. States with some penalty for program non-compliance were more likely to perceive their programs to be cost-effective.

1. Prevalence and Program Characteristics

Survey responses indicate that ambulatory surgery programs are a relatively common state Medicaid cost-containment strategy. About 65 percent of states (32 states) reported having an ambulatory surgery program in place in 1993. An additional six percent of states reported plans to introduce ambulatory surgery programs in the future, while 27 percent reported never having tried this cost-containment approach.

About half of all ambulatory surgery programs began operating between 1985 and 1989. Only seven percent of states reported that they had implemented ambulatory surgery programs before 1980. In contrast, both preadmission testing policy and same-day admission surgery policy programs were more likely to be implemented either before 1980 or in the first half of the decade. Table III.4 illustrates this information and related program characteristics identified by the survey.

Almost all state Medicaid ambulatory surgery programs cover all recipients (97 percent). As would be expected given the ever-changing nature of technology, most states with a program have plans to revise the lists of procedures targeted, most often to increase the number. Of the 14 states that sent their list of targeted procedures, all but one targeted more than 200 procedures.

We also found that Medicaid ambulatory surgery programs:

- Used a variety of methods to develop their procedure lists, including borrowing from other Medicaid programs (34 percent), borrowing from non-Medicaid programs (44 percent), and using the recommendations of medical consultants (56 percent).

TABLE III.4
AMBULATORY SURGERY PROGRAM
BACKGROUND INFORMATION

	Percent of States (unless otherwise noted)
Number of states with program:	32
Calendar year program began	
Before 1980	7
1980 - 1984	27
1985 - 1989	50
1990 - 1993	13
1994	3
Recipients covered	
All recipients	97
A subset of recipients	3
Geographic area covered	
Statewide	100
Limited geographic area	0
Plans for the program	
Discontinue	0
Change the procedures targeted	78
Expand the geographic area	0
Expand to additional recipient groups	0
Other change	22

- For the most part required rather than encouraged that the specified procedures be performed on an outpatient basis (63 percent).
- For the most part allowed exceptions to the requirement for emergency and certain other cases (80 percent and 70 percent, respectively).

State monitoring of ambulatory surgery programs was common and extensive, with most states monitoring all cases for compliance (63 percent) and denying payment in the event of noncompliance (74 percent). Only five states (16 percent) reported no penalty for noncompliance.

2. Ambulatory Surgery Programs' Impact on Costs

Eighty percent of states with programs perceived that the program had some beneficial effect on Medicaid costs (Table III.5). The remaining states were evenly split between perceptions that their ambulatory surgery programs were strongly beneficial, were ineffective or adversely affected Medicaid costs.

States that require specific procedures be performed on an outpatient basis reported similar levels of perceived cost-savings as states that only encourage this. However, states with some penalty for non-compliance were more likely to perceive their programs to be cost-saving than states with no penalty for non-compliance (92 versus 60 percent).

Only 20 percent of states with programs reported that they had conducted any sort of evaluation of their ambulatory surgery programs. Eighty-six percent of those states had completed their first program evaluations between 1990 and 1993. All but one of these evaluations was an internal evaluation by the state Medicaid agency.

3. Impact on Quality of Care and Access to Care

None of the states with ambulatory surgery programs reported an adverse impact on quality of care as a result of their program. More than half of the states (60 percent) reported the program had no impact on quality of care, while 37 percent reported that their programs had some beneficial impact on quality. Only one state reported a strong beneficial effect on quality.

TABLE III.5
AMBULATORY SURGERY PROGRAM IMPORTANCE AND IMPACT

	Percent of States
Perceived impact on Medicaid costs	
Severe adverse effect	3
Some adverse effect	3
No significant effect	7
Some beneficial effect	80
Strong beneficial effect	7
Perceived impact on quality	
Some adverse effect	0
No significant effect	60
Some beneficial effect	37
Strong beneficial effect	3
Perceived impact on access	
Some adverse effect	0
No significant effect	72
Some benefit	21
Strong benefit	7
Any evaluation	
Yes	20
No	80
Year last evaluation completed	
Before 1985	0
1985 - 1989	14
1990 - 1993	85

Similarly, a majority (72 percent) of states thought that the program had no impact on access, while 28 percent found at least some benefit in terms of access. No states perceived their program's impact on access to be negative.

IV. SAME-DAY ADMISSION SURGERY AND PREADMISSION TESTING PROGRAMS

A. OVERVIEW

Same-day admission surgery programs attempt to control costs by encouraging or requiring individuals to be admitted to the hospital on the day of surgery. Preadmission testing programs try to reduce expenditures by requiring that certain routine diagnostic tests be performed before hospital admission or surgery on an outpatient basis. Since the two programs employ the same cost reduction strategy—shifting the locus of care for routine diagnostic tests to outpatient settings, such as hospital ancillary departments, licensed laboratories, physicians' offices, and ASCs—they are discussed together in this section. Similar to ambulatory surgery programs, same-day admission surgery and preadmission testing programs may either *encourage* the performance of tests on an outpatient basis through payment policies that provide financial incentives to enrollees or physicians to select an outpatient setting for the tests or they may *require* such a choice.

B. BACKGROUND AND FINDINGS FROM THE LITERATURE

1. Assumptions Underlying Same-Day Admission Surgery and Preadmission Testing Programs

Same-day admission surgery and preadmission testing programs are generally assumed to reduce costs by decreasing the length of inpatient stays. Stays are shortened by eliminating early admission for routine testing and identifying previously undiagnosed conditions that can delay surgery and/or prolong hospitalization.

One of the greatest determinants of total hospital charges is the length of stay (Loop et al. 1983; Keithley et al. 1989). Authors of a study of 25 coronary bypass patients found that before the use of same-day admission surgery and preadmission testing programs, patients who underwent elective surgery were frequently admitted to the hospital up to two days before surgery for routine testing and evaluation of medical problems (Loop et al. 1983). Thus, requiring routine tests and evaluation to be performed in an outpatient setting would automatically reduce the length of stay. With the

average cost of a day of hospital care at \$844 in 1991, this reduction would also reduce health care costs (U.S. House of Representatives, Committee on Ways and Means 1992). However, this reasoning tends to overstate the savings because the cost of preoperative days are generally less expensive than the cost of an average hospital day.¹

Preoperative tests allow the physician to plan for the management of the patient before, during, and after the surgery in order to minimize morbidity (Roizen 1989). Discovering abnormalities during preoperative testing may result in the cancellation or postponement of scheduled surgery. Identifying potential problems like these before admission would therefore reduce inpatient hospital stays, thereby lowering health care costs.

2. Trends in the Prevalence of Same-Day Admission Surgery and Preadmission Testing Programs

Same-day admission surgery and preadmission testing programs were first developed in the 1970s and became popular during the 1980s in both the private and public sectors. The Wyatt Company's Group Benefits Surveys (1984) found that preadmission testing programs were among the most prevalent cost-containment measure adopted by employers, with 87 percent of the core group of 170 employers using preadmission testing in 1984. This percentage remained constant at a little over 80 percent through 1986 and 1988 (The Wyatt Company 1986 and 1988). Like ambulatory surgery, the extensive implementation of same-day admission surgery and preadmission testing programs prompted widespread acceptance of the programs as well as changes in provider practice patterns. Today, hospitals and physicians very rarely admit patients for preoperative testing (Sally Bleeks, telephone interview, October 23, 1992).

¹Such promising results from the early 1980s may also overstate savings due to changes in medical practice since that time if the changes made preoperative stays less common even without a program (discussed below).

3. Same-Day Admission Surgery Programs: the Evidence and Its Limitations

In our literature review, we found only two studies that examined the impact of same-day admission surgery programs on health care costs. While both studies found that the programs produced cost-savings, they were methodologically weak. Because these weaknesses work to bias both studies toward overstating the savings attainable through such programs, we cannot say anything definitive about the impact of same-day admission surgery programs on health care costs.

Loop et al. (1983) prospectively studied 25 same-day admission coronary bypass patients and compared their costs with the costs of 25 other randomly selected routinely admitted coronary bypass patients from each of the years 1977 to 1981. They concluded that on average, same-day admission surgery patients saved two days of hospitalization and incurred charges that were 10 percent lower than the comparison group. Shorter lengths of stay accounted for the greatest savings.

The second study by Keithley et al. (1989) prospectively studied 59 matched pairs of same-day admission surgery patients and routinely admitted patients in a tertiary care center. The patients were matched on surgical procedure, age, and type of anesthesia. They concluded that same-day admission surgery patients had lengths of stay of almost two days less than the routinely admitted patients, and that the total hospital charges for the duration of their stays were on average \$1,200 less than their routinely admitted counterparts.

Both studies share the analytical flaws discussed earlier found in studies on the impact of ambulatory surgery programs on health care costs. Neither study controlled for the severity of illness in comparing the costs of patients admitted under the same-day admission surgery programs with the comparison group of routinely admitted patients. This oversight would overestimate the savings attainable through mandatory same-day admission surgery programs if there were systematic differences between the two groups of patients. Since the programs were voluntary, the patients admitted under these programs are likely to have had less severe conditions even if the same procedures were being performed.

4. Preadmission Testing Programs: the Evidence and Its Limitations

In our literature review, we did not find any studies that specifically examined the impact of preadmission testing programs on health care costs. However, we did find studies that suggest that there is general agreement on the question of whether preadmission testing programs save money as a result of shifting routine tests to the outpatient setting. Performing routine preoperative tests in outpatient settings is widely accepted, and physicians today have standard order sheets for entire panels of tests that they order on a regular basis for all patients undergoing surgery. The standard panel generally includes chest x-rays and electrocardiograms for patients older than 40, urinalysis, complete blood count, and different chemistry panels. The battery may also include additional tests, depending on the patient's health status, the type of procedure performed, and the physician (telephone interview, L. Reuven Pasternak, Medical Director of Outpatient Surgery Programs, Johns Hopkins Medical Center, November 11, 1992).

Recent evidence suggests that while preadmission testing is widely accepted, preadmission testing policies could produce additional cost savings if they focused on reducing the number of diagnostic tests performed. In 1984, Blue Cross/Blue Shield estimated that of the \$30 billion spent on preoperative testing in the U.S. that year, between \$12 billion and \$18 billion could have been saved if the only tests performed were those indicated as necessary by a patient's medical history (Roizen 1989). In an attempt to streamline preoperative testing and develop clinical guidelines for the types of preoperative tests that should be performed in different situations, the Johns Hopkins Medical Center recently eliminated all routine preoperative tests for patients younger than 50 who have no health conditions (Same-Day Surgery 1991; L. Reuven Pasternak, telephone interview, November 11, 1992). According to Dr. Pasternak, many excessive, unnecessary diagnostic tests were performed before the development and implementation of the clinical guidelines. The guidelines were created to reduce the number of routinely performed tests, but the potential for reduction was even greater than anticipated. So far, the medical center reports finding no adverse clinical events

from the new guidelines, and the Centers' cancellation rate for surgery has fallen since the guidelines were implemented.

The common argument for the routine performance of a battery of tests is that they lead to the discovery of previously undiagnosed conditions that may delay surgery or cause complications. However, the evidence indicates otherwise, showing that lab tests are ineffective both in screening for asymptomatic diseases when they are not indicated by either the patient's history or a physical (Durbridge et al. 1976; Wood and Hoekelman 1981; Kaplan et al. 1985).

- Durbridge et al. studied 1,500 patients randomly assigned to undergo or forego screening tests on admission and found that the 8,363 tests that were performed were not beneficial in terms of length of stay and patient outcomes.
- Wood and Hoekelman conducted a study on 1,924 children who had undergone surgeries and discovered that only 3 of the 28 children who had their surgeries delayed had abnormal lab tests that were not indicated by the history or physical examination. No differences, however, were found in the anesthetic preoperative complications for the two groups.
- Kaplan et al. examined 2,785 routine preoperative diagnostic tests and found that roughly 60 percent of the tests were unindicated, with a test-specific range of 34 percent to 90 percent. Of the 96 tests that indicated the presence of abnormalities, only 10 of the tests were performed in the unindicated group, and only 4 of those 10 resulted in the discovery of abnormalities of potential surgical significance. Furthermore, no alterations in patient care as a result of the abnormalities were discernible from a chart review of those 10 patients.

Studies also suggest that universal preoperative testing may actually lead to postponing surgery more often because most abnormalities are not discovered until the night before or the morning of the scheduled surgery (Roizen 1989). Thus, the evidence seems to suggest that (1) performing a routine battery of preoperative tests results in unnecessary costs and (2) preadmission testing programs may have the potential to produce cost savings if they focus on reducing unnecessary preoperative testing.

5. Impact on Quality of Care and Access to Health Care

We found no direct evidence on the impact on quality or access to care of preadmission testing programs and same-day admission surgery programs. However, logic and indirect evidence suggest that:

- Same-day admission surgery and preadmission testing programs probably do not compromise quality of care
- There may be potential for reduced access to care from additional visits for preoperative care that result from these programs, although no studies have examined this potential.

a. Quality of Care

Neither of the two studies that examined the impact of same-day admission surgery programs on health care costs addressed quality of care. However, although same-day admission surgery programs require only preoperative tests, not more invasive procedures, to be performed in an outpatient setting, the evidence shows that performing even complex and invasive procedures in an outpatient setting does not adversely affect quality of care. It is therefore unlikely that performing less complex procedures such as preoperative tests in an outpatient setting would adversely affect the quality of care. As a result, it appears unlikely that same-day admission surgery programs would adversely affect the quality of care.

Our literature search did not yield articles that focused specifically on the impact of shifting preoperative diagnostic tests from the inpatient to the outpatient setting on quality of care. However, the general consensus seemed to be that the quality of such tests had not been compromised by the shift in site. We did find one study on the impact of unnecessary preoperative tests on the quality of care. This retrospective 1987 study of 386 individuals who had chest x-rays that were not indicated found that the x-rays revealed only one problem in the 386 cases. Only in the single case may the x-ray have helped to improve care. Invasive follow-up tests were performed on three other individuals based on indications from the chest x-rays: no disease was discovered.

and the patients experienced considerable morbidity (Roizen et al. 1987). Because the evidence is sparse, we cannot say anything conclusive about the impact of unnecessary preoperative tests on quality of care. The evidence we did find seems to suggest that these tests neither improve nor compromise quality of care.

b. Access to Care

Same-day admission surgery and preadmission testing programs could adversely affect access to care by increasing the number of trips necessary to obtain care if the patient has to make an additional trip for preoperative tests. Additional travel costs are not reimbursed by Medicaid and may disproportionately affect Medicaid beneficiaries' access because of their low-income status. This concern is especially significant for Medicaid beneficiaries in rural areas for whom the closest Medicaid-participating provider may be many miles away. However, none of the studies we found on same-day admission surgery or preadmission testing specifically examined the impact of such programs on access to care for the general or the Medicaid population.

In developing guidelines on preoperative testing, the Johns Hopkins Medical Center considered the inconvenience and potential barriers to access caused by additional trips for preoperative tests in the following ways:

- Adopted a rule that allows primary care providers, especially those whose patients live a considerable distance from the hospital, to perform the initial assessments and tests, and send them to the university for review.
- Established guidelines on the types of patients who could have the necessary preoperative tests and assessments performed on the day of the surgery (*Same-Day Surgery* 1991).

According to Dr. Pasternak, the Center had accepted results of preoperative tests from licensed laboratories before adopting the new guidelines, but it had never had an explicit policy on the issue. Other hospitals may or may not have the same type of policy.

Although we did not find any studies that examined the impact of same-day surgery and preadmission testing programs on access to care, the action taken by Johns Hopkins to reduce the inconvenience caused by additional trips for preoperative tests suggests that the potential for an access problem associated with these programs was a concern.

6. Desirable Program Features

Some of the literature on preadmission testing programs recommends, on the basis of predetermined indications, the selective ordering of preoperative tests in place of the routine battery of tests currently performed. Also recommended is a set of guidelines on the indications for specific preoperative tests. The selective use of preoperative tests would reduce costs, and the studies presented earlier seem to indicate that such tests would not adversely affect quality of care.

There is evidence in the literature that appropriate preoperative testing can be determined by the surgeon in an initial preoperative assessment. For example, Kaplan et al. found that from October 1980 to January 1981, all but 10 abnormalities in 2,785 preoperative blood tests were predicted when (1) the physician was aware of the admission diagnosis, previous discharge diagnoses, and the scheduled operation, and (2) predetermined indications were used. Only 4 of the 10 abnormal results from unindicated tests were of potential surgical significance.

Guidelines on the indications for specific preoperative tests would allow the selective use of preoperative tests. Johns Hopkins formed a consensus committee to develop such guidelines. The committee, which included representatives from anesthesiology, surgery, gynecology, internal medicine, cardiology, and nursing, developed a risk classification system based on surgical procedure categories and American Society of Anesthesia (ASA) anesthesia classes, determined which patients needed to be seen before the day of surgery based on their risk classification, and determined the tests that should be performed (*Same-Day Surgery* 1991). The anesthesiologist retains the option of deferring on even the recommended test if there are no indications (L. Reuven Pasternak, telephone interview, November 11, 1992).

C. SURVEY RESULTS: STATE MEDICAID PREADMISSION TESTING POLICIES

While relatively few states have preadmission testing policies in place, all that do perceive their policies to have a positive impact on Medicaid costs. Additionally, no state believes its testing policy detrimental to access or quality of care.

1. Prevalence and Program Characteristics

Of all the Medicaid cost-containment programs we inventoried, preadmission testing was the least frequently implemented. Only 22 percent of states reported having preadmission testing policies in place. Nearly all states (91 percent) reported that the policy extends to all state Medicaid recipients, and all are statewide policies. One state reported plans to change the procedures targeted by the policy; no other changes were reported.

Twenty-seven percent of states reported plans to implement preadmission testing policies, while one state reported that its policy had recently been discontinued. Only a few additional states (5 percent) without the policy reported ever considering its implementation. About a third of states without testing policies reported that instituting the policy would duplicate other activities already in place. The same proportion believe that the costs of policy implementation would probably exceed its benefits. Table IV.1 illustrates this information and related program characteristics identified by our survey.

Most states with policies (73 percent) reported that they do not target specific tests or admissions but rather generally require or encourage preadmission testing. More than half the states with the policy (64 percent) reported that they require outpatient testing, rather than encouraging it. Slightly more than half of all states with the program (55 percent) deny payment in cases of policy non-compliance, while about 27 percent of the remaining states impose a partial penalty for non-compliance.

We also found that Medicaid preadmission testing policies:

TABLE IV.1
PREADMISSION TESTING POLICY
BACKGROUND INFORMATION

	Percent of States (unless otherwise noted)
Total Number of States with Preadmission Testing Policy	11
Calendar Year Program Began	
Before 1980	38
1980 - 1984	25
1985 - 1989	25
1990 - 1993	0
1994	12
Recipients Covered	
All Recipients	91
A Subset of Recipients	9
Geographic Area Covered	
Statewide	100
Limited Geographic Area	0
Plans for the Program	
No Change	91
Discontinue	0
Change the Procedures Targeted	9
Expand the Geographic Area	0
Expand to Additional Recipient Groups	0
Other Change	0

- Generally exempt emergency and certain other specified types of hospital admissions (90 percent and 60 percent, respectively)
- Are likely to monitor all cases for policy compliance (67 percent).

- 2. Impact on Costs

All states reported that their policies had either some or a strong beneficial effect on costs. States that required outpatient testing, rather than merely encouraging the policy, were more likely to report a strong cost benefit associated with the policy (50 versus 25 percent). Similarly, states that imposed either a partial payment penalty or denied payments for non-compliance were 44 percent more likely to report a strong cost benefit associated with the program. However, states that did not impose penalties nevertheless believed their policies had some positive impact on costs. Table IV.2 provides additional information about the perceived cost effects of preadmission testing policies.

3. Impact on Quality of Care and Access to Care

None of the states with preadmission testing policies perceived that they lowered the quality of care. More than half of the states (67 percent) reported that their policies had no effect on quality of care, while the remaining third reported that their policies had somewhat improved quality of care.

About 89 percent of states reported that their policies had no perceived program impact on access to care. The remaining states believed that the policy had improved access to care.

D. SURVEY RESULTS: STATE MEDICAID SAME-DAY SURGERY PROGRAMS

We found that all states with same-day admission surgery policies believed their programs helped reduce or limit Medicaid costs. None of the states thought their policies lowered the quality

TABLE IV.2
PREADMISSION TESTING POLICY IMPORTANCE AND IMPACT

	Percent of States (unless otherwise noted)
Perceived impact on Medicaid costs	
Severe adverse effect	0
Some adverse effect	0
No significant effect	0
Some beneficial effect	60
Strong beneficial effect	40
Perceived impact on quality	
Some adverse effect	0
No significant effect	67
Some beneficial effect	33
Strong beneficial effect	0
Perceived impact on access to care	
Some adverse effect	0
No significant effect	89
Some beneficial effect	11
Strong beneficial effect	0
Any evaluation	
Yes	9
No	91
Year last evaluation completed	
Before 1990	0
1990 - 1993	100

of care for Medicaid recipients or made appropriate care less accessible--the majority of states reported that their policies had no effect on quality and access to health care.

1. Prevalence and Program Characteristics

Slightly less than a third of states (31 percent) reported having same-day admission surgery policies. About 42 percent of those states instituted their policies before 1980, and most of the rest adopted their policies during the 1980s. The policies were broadly applied; all states reported that their policies applied statewide, and nearly all (92 percent) covered all Medicaid recipients. None of the states reported plans to change their same-day surgery policies. Table IV.3 illustrates this information and other program characteristics captured by the survey.

States without same-day surgery policies have little or no interest in their implementation. Only one state plans to implement the policy, and two states reported that they have discontinued theirs. About 10 percent of states without the policy reported that they had once considered its implementation. Close to a third of states without the policy expect that its costs would exceed its benefits. About the same proportion reported that the policy would duplicate other cost-containment efforts already underway. Only 15 percent of states with policies have ever conducted evaluations of them.

We also found that Medicaid same-day admission surgery policies:

- Are more likely to be sets of general guidelines than attempts to target specific surgical procedures (85 versus 15 percent)
- Are more likely to encourage than to require that patients be admitted the day of surgery (62 versus 38 percent)
- Usually make exceptions for special instances (92 percent)
- Are likely to include a payment penalty for non-compliance (85 percent).

TABLE IV.3

SAME-DAY ADMISSION SURGERY POLICY BACKGROUND INFORMATION

	Percent of States (unless otherwise noted)
Total number with program:	15
Calendar year program began	
Before 1980	42
1980 - 1984	17
1985 - 1989	33
1990 - 1993	8
Recipients covered	
All recipients	92
A subset of recipients	8
Geographic area covered	
Statewide	100
Limited geographic area	0
Plans for the program	
No change	100
Discontinue, or other change	0

2. Impact on Costs

All states reported that their policies had some beneficial effect on Medicaid costs. However, only a few states with required policies (40 percent) reported a strong cost benefit; this was a greater percentage of states than reported strong benefits for most other programs in our survey. Table IV.4 presents program impact and cost-effectiveness information from our survey.

3. Impact on Access to Care and Quality of Care

About half the states (58 percent) reported that quality of care is unaffected by the policy. The remaining 42 percent believe that their policies have improved the quality of care.

Similarly, a majority of states (92 percent) saw no connection between the program and recipients' access to care. The remaining proportion believe that the program has improved access. No states reported that their policies had adversely affected access to care.

TABLE IV.4
SAME-DAY ADMISSION SURGERY POLICY IMPORTANCE AND IMPACT

	Percent of States
Perceived impact on Medicaid costs	
Severe adverse effect	0
Some adverse effect	0
No significant effect	0
Some beneficial effect	85
Strong beneficial effect	15
Perceived impact on quality	
Some adverse effect	0
No significant effect	58
Some beneficial effect	33
Strong beneficial effect	9
Perceived impact on access to care	
Some adverse effect	0
No significant effect	92
Some beneficial effect	8
Strong beneficial effect	0
Any evaluation	
Yes	15
No	85
Year last evaluation completed	
Before 1990	0
1990 - 1993	100

V. CONCLUSIONS

Based on our study, we recommend the Medicaid program not require states to have ambulatory surgery, preadmission testing, and same-day surgery programs. The effectiveness of these three programs is unclear from research to date, and even if presumed effective they must be considered in the context of the many cost-containment options available to states, including managed care options now being considered and implemented in many states by themselves or in conjunction with a broader health reform strategy.

States perceive ambulatory surgery, preadmission testing programs, and same-day surgery programs to be less beneficial cost-containment measures than many of the other types of programs in our survey. Ambulatory surgery was the only one of the three types of programs that was frequently implemented, and there was little interest in states without programs in place to implement these three types of programs—many believed the costs of the program would outweigh the benefits.

The lack of recent or methodologically sound research on these three types of programs meant our literature review provided little help in drawing conclusions on the impact of these three programs. Although ambulatory surgery programs were most strongly supported in studies completed in the 1970s or early 1980s, the most recent study (Pauly and Erder 1993) casts doubt on even this.

Ambulatory surgery, preadmission testing, and same-day surgery programs should still remain an option for states, however, since we found nothing to suggest they have an adverse impact on access to care or quality of care, and many of the states that have implemented these programs report "some" benefit in terms of cost reduction. Modest benefits were more often reported for preadmission testing and same-day surgery than for ambulatory surgery, where a majority of states found a neutral effect on costs.

The following findings on specific program characteristics should be considered if any of these programs are mandated, and these findings may be useful to states in reviewing their programs in comparison with the norm for states with each type of program:

- *Ambulatory Surgery.* States with some penalty for noncompliance were more likely to perceive their programs to be cost-saving than states with no penalty for noncompliance (92 versus 60 percent). Also, states generally targeted specific procedures in their ambulatory surgery programs (all but one reported over 200 procedures targeted), the procedure lists overlapped but differed from one another, and most have plans to revise their lists to keep up with changing technology. This suggests (1) there is no consensus list of procedures that could be mandated for this programs, and (2) if a procedure list were mandated, it would require periodic updates.
- *Preadmission Testing.* With the small number of states implementing preadmission testing programs, we could not discern any clear patterns in the characteristics of programs perceived more cost-saving. However, the majority of states (1) used a general requirement rather than targeting specific admissions or tests, (2) required rather than encouraged preadmission testing, (3) deny payment in cases of policy noncompliance, and (4) generally exempt emergency and certain other specified types of admissions.
- *Same-Day Surgery.* Similar to preadmission testing, there were no discernable patterns in the characteristics of programs perceived very cost-saving versus others. However, a majority of programs (1) provide general guidelines rather than targeting specific procedures, (2) are more likely to encourage than to require that patients be admitted on the same day as surgery, (3) usually make exceptions for special cases, and (4) include some payment penalty for noncompliance.

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Appendix B

**Surgical Procedures Covered By Medicare When
Performed in Ambulatory Surgery Centers**

Addendum A - List of Covered Surgical ProceduresINTEGUMENTARY SYSTEMSKIN, SUBCUTANEOUS AND AREOLAR TISSUESINCISION

10180 2 Incision and drainage, complex, postoperative wound infection

EXCISION DEBRIDEMENT

11042 2 Debridement; skin, and subcutaneous tissue
11043 2 Debridement; skin, subcutaneous tissue, and muscle
11044 2 Debridement; skin, subcutaneous tissue, muscle, and bone

EXCISION-BENIGN LESIONS

11404 1 Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs, lesion diameter 3.1 to 4.0 cm
11406 2 Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter over 4.0 cm
11424 2 Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
11426 2 Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
11444 1 Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane, lesion diameter 3.1 to 4.0 cm
11446 2 Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm
11450 2 Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
11451 2 Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair
11462 2 Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair
11463 2 Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repair
11470 2 Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair
11471 2 Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair

EXCISION-MALIGNANT LESIONS

11604 2 Excision, malignant lesion, trunk, arms, or legs; lesion diameter 3.1 to 4.0 cm
11606 2 Excision, malignant lesion, trunk, arms, or legs; lesion diameter over 4.0 cm
11624 2 Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
11626 2 Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
11644 2 Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 3.1 to 4.0 cm

- 11646 2 Excision, malignant lesion, face, ears, eyelids, nose, lips;
lesion diameter over 4.0 cm

MISCELLANEOUS

- 11770 3 Excision of pilonidal cyst or sinus; simple
11771 3 Excision of pilonidal cyst or sinus; extensive
11772 3 Excision of pilonidal cyst or sinus; complicated

INTRODUCTION

- 11960 2 Insertion of tissue expander(s) for other than breast,
including subsequent expansion
11970 3 Replacement of tissue expander with permanent prosthesis
11971 1 Removal of tissue expander(s) without insertion of prosthesis

REPAIR-SIMPLE

- 12005 2 Simple repair of superficial wounds of scalp, neck, axillae,
external genitalia, trunk and/or extremities (including
hands and feet); 12.6 cm to 20.0 cm
12006 2 Simple repair of superficial wounds of scalp, neck, axillae,
external genitalia, trunk and/or extremities (including hands
and feet); 20.1 cm to 30.0 cm
12007 2 Simple repair of superficial wounds of scalp, neck, axillae,
external genitalia, trunk and/or extremities (including hands
and feet); over 30.0 cm
12016 2 Simple repair of superficial wounds of face, ears, eyelids,
nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12017 2 Simple repair of superficial wounds of face, ears, eyelids,
nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018 2 Simple repair of superficial wounds of face, ears, eyelids,
nose, lips and/or mucous membranes; over 30.0 cm
12020 1 Treatment of superficial wound dehiscence; simple closure
12021 1 Treatment of superficial wound dehiscence; with packing

REPAIR-INTERMEDIATE

- 12034 2 Layer closure of wounds of scalp, axillae, trunk and/or
extremities (excluding hands and feet); 7.6 cm to 12.5 cm
12035 2 Layer closure of wounds of scalp, axillae, trunk and/or
extremities (excluding hands and feet); 12.6 cm to 20.0 cm
12036 2 Layer closure of wounds of scalp, axillae, trunk and/or
extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037 2 Layer closure of wounds of scalp, axillae, trunk and/or
extremities (excluding hands and feet); over 30.0 cm
12044 2 Layer closure of wounds of neck, hands, feet and/or external
genitalia; 7.6 cm to 12.5 cm
12045 2 Layer closure of wounds of neck, hands, feet and/or external
genitalia; 12.6 cm to 20.0 cm
12046 2 Layer closure of wounds of neck, hands, feet and/or external
genitalia; 20.1 cm to 30.0 cm
12047 2 Layer closure of wounds of neck, hands, feet and/or external
genitalia; over 30.0 cm
12054 2 Layer closure of wounds of face, ears, eyelids, nose, lips
and/or mucous membranes; 7.6 cm to 12.5 cm
12055 2 Layer closure of wounds of face, ears, eyelids, nose, lips
and/or mucous membranes; 12.6 cm to 20.0 cm
12056 2 Layer closure of wounds of face, ears, eyelids, nose, lips
and/or mucous membranes; 20.1 cm to 30.0 cm
12057 2 Layer closure of wounds of face, ears, eyelids, nose, lips
and/or mucous membranes; over 30.0 cm

REPAIR-COMPLEX

13100	2	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	3	Repair, complex, trunk; 2.6 cm to 7.5 cm
13120	2	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	3	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13131	2	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	3	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13150	3	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
13151	3	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152	3	Repair, complex, eyelids, nose, ears, and/or lips; 2.6 cm to 7.5 cm
13160	2	Secondary closure of surgical wound or dehiscence, extensive or complicated
13300	4	Repair, unusual, complicated, over 7.5 cm, any area

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

14000	2	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	3	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	3	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	3	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	2	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	3	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	3	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	3	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14300	4	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area
14350	3	Filletted finger or toe flap, including preparation of recipient site

FREE SKIN GRAFTS

15000	2	Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft)
15050	2	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter
15100	2	Split graft, trunk, scalp, arms, legs, hands, and/or feet except multiple digits; 100 sq cm or less, or each one percent of body area of infants and children (except 15050)
15101	3	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); each additional 100 sq cm, or each one percent body area of infants and children, or part thereof
15120	2	Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; 100 sq cm or less, or each

- one percent of body area of infants and children (except 15050)
- 15121 3 Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof
- 15200 3 Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
- 15201 2 Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm
- 15220 2 Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
- 15221 2 Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm
- 15240 3 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 20 sq cm or less
- 15241 3 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 20 sq cm
- 15260 2 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
- 15261 2 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm
- 15350 2 Application of allograft (homograft), skin
- 15400 2 Application of xenograft, skin
- 15570 3 Formation of direct or tubed pedicle, with or without transfer; trunk
- 15572 3 Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
- 15574 3 Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
- 15576 3 Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips or intraoral
- 15580 3 Cross finger flap, including free graft to donor site
- 15600 3 Delay of flap or sectioning of flap (division and inset); at trunk
- 15610 3 Delay of flap or sectioning of flap (division and inset); at scalp, arms, or legs
- 15620 4 Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands (except 15625), or feet

PEDICLE FLAPS (SKIN AND DEEP TISSUES)

- 15625 3 Delay of flap or sectioning of flap (division and inset); section pedicle of cross finger flap
- 15630 3 Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips
- 15650 5 Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, "Walking tube"), any location

FLAPS (SKIN AND/OR DEEP TISSUES)

- 15732 3 Muscle, myocutaneous, or fasciocutaneous flap; head and neck

- (eg, temporalis, masseter, sternocleidomastoid, levator scapulae)
- 15734 3 Muscle, myocutaneous, or fasciocutaneous flap; trunk
- 15736 3 Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
- 15738 3 Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

OTHER GRAFTS

- 15740 2 Flap; island pedicle
- 15750 2 Flap; neurovascular pedicle
- 15755 3 Flap; free flap (microvascular transfer)
- 15760 2 Graft; composite (full thickness of external ear or nasal ala), including primary closure, donor area
- 15770 3 Graft; derma-fat-fascia

MISCELLANEOUS PROCEDURES

- 15840 4 Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
- 15841 4 Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
- 15842 4 Graft for facial nerve paralysis; free muscle graft by microsurgical technique
- 15845 4 Graft for facial nerve paralysis; regional muscle transfer

PRESSURE ULCERS (DECUBITUS ULCERS)

- 15920 3 Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
- 15922 4 Excision, coccygeal pressure ulcer, with coccygectomy; with flap closure
- 15931 3 Excision, sacral pressure ulcer, with primary suture
- 15933 3 Excision, sacral pressure ulcer, with primary suture; with ostectomy
- 15934 3 Excision, sacral pressure ulcer, with skin flap closure
- 15935 4 Excision, sacral pressure ulcer, with local or regional skin flap closure (eg, advancement rotation, rhomboid, bipedicle); with ostectomy
- 15936 4 Excision, sacral pressure ulcer, with muscle or myocutaneous flap closure
- 15937 4 Excision, sacral pressure ulcer, with other flap closure; with ostectomy
- 15940 3 Excision, ischial pressure ulcer, with primary suture
- 15941 3 Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischietomy)
- 15944 3 Excision, ischial pressure ulcer, with skin flap closure
- 15945 4 Excision, ischial pressure ulcer, with skin flap closure; with ostectomy
- 15946 4 Excision, ischial pressure ulcer, with ostectomy, with muscle or myocutaneous flap closure
- 15950 3 Excision, trochanteric pressure ulcer, with primary suture
- 15951 4 Excision, trochanteric pressure ulcer, with primary suture; with ostectomy
- 15952 3 Excision, trochanteric pressure ulcer, with skin flap closure
- 15953 4 Excision, trochanteric pressure ulcer, with skin flap closure; with ostectomy
- 15956 3 Excision, trochanteric pressure ulcer, with muscle or myocutaneous flap closure
- 15958 4 Excision, trochanteric pressure ulcer, with muscle or myocutaneous flap closure; with ostectomy

BURNS, LOCAL TREATMENT

- 16015 2 Dressing and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement
 16030 1 Dressings and/or debridement, initial or subsequent; without anesthesia, large (eg, more than one extremity)
 16035 2 Escharotomy

BREASTINCISION

- 19020 2 Mastotomy with exploration or drainage of abscess, deep

EXCISION

- 19100 1 Biopsy of breast; needle (separate procedure)
 19101 2 Biopsy of breast; incisional
 19110 2 Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct
 19112 3 Excision of lactiferous duct fistula
 19120 3 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions
 19125 3 Excision of breast lesion identified by pre-operative placement of radiological marker; single lesion
 19126 3 Excision of breast lesion identified by pre-operative placement of radiological marker; each additional lesion separately identified by a radiological marker
 19140 4 Mastectomy for gynecomastia through circumareolar or other incision
 19160 3 Mastectomy, partial
 19162 7 Mastectomy, partial; with axillary lymphadenectomy
 19180 4 Mastectomy, simple, complete
 19182 4 Mastectomy, subcutaneous
 19260 5 Excision of chest wall tumor including ribs

REPAIR AND RECONSTRUCTION

- 19318 4 Reduction mammoplasty
 19328 1 Removal of intact mammary implant
 19330 1 Removal of mammary implant material
 19340 2 Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
 19342 3 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
 19350 4 Nipple/areola reconstruction
 19357 5 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
 19364 5 Breast reconstruction with free flap
 19366 5 Breast reconstruction with other technique
 19370 4 Open periprosthetic capsulotomy, breast
 19371 4 Periprosthetic capsulectomy, breast
 19380 5 Revision of reconstructed breast

MUSCULOSKELETAL SYSTEMGENERALINCISION

- 20005 2 Incision of soft tissue abscess (e.g., secondary to osteomyelitis); deep or complicated

EXCISION

- 20200 2 Biopsy, muscle; superficial

20205 3	Biopsy, muscle; deep
20206 1	Biopsy, muscle, percutaneous needle

20220	1	Biopsy, bone, trocar or needle; superficial (eg, ilium, sternum, spinous process, ribs)
20225	2	Biopsy, bone, trocar or needle; deep (vertebral body, femur)
20240	2	Biopsy, excisional; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)
20245	3	Biopsy, excisional; deep (eg, humerus, ischium, femur)
20250	3	Biopsy, vertebral body, open; thoracic
20251	3	Biopsy, vertebral body, open; lumbar or cervical

INTRODUCTION OR REMOVAL

20525	3	Removal of foreign body in muscle or tendon sheath; deep or complicated
20650	3	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
20660	2	Application of cranial tongs caliper, or stereotactic frame including removal (separate procedure)
20661	3	Application of halo, including removal; cranial
20662	3	Application of halo, including removal; pelvic
20663	3	Application of halo, femoral
20665	1	Removal of tongs or halo applied by another physician
20670	1	Removal of implant; superficial, (eg, buried wire, pin or rod) (separate procedure)
20680	3	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)
20690	2	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system

GRAFTS (OR IMPLANTS)

20900	3	Bone graft, any donor area; minor or small (eg, dowel or button)
20902	4	Bone graft, any donor area; major or large
20912	3	Cartilage graft; nasal septum
20920	4	Fascia lata graft; by stripper
20922	3	Fascia lata graft; by incision and area exposure, complex or sheet
20924	4	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)
20926	4	Tissue grafts, other (eg, paratenon, fat, dermis)

MISCELLANEOUS

20955	4	Bone graft with microvascular anastomosis; fibula
20960	4	Bone graft with microvascular anastomosis; rib
20962	4	Bone graft with microvascular anastomosis; other bone graft (specify)
20969	4	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, rib, metatarsal, or great toe
20970	4	Free osteocutaneous flap with microvascular anastomosis; iliac crest
20971	4	Free osteocutaneous flap with microvascular anastomosis; rib
20972	4	Free osteocutaneous flap with microvascular anastomosis; metatarsal
20973	4	Free osteocutaneous flap with microvascular anastomosis; great toe with web space
20975	2	Electrical stimulation to aid bone healing; invasive (operative)

HEAD

INCISION

21010 2 Arthrotomy, temporomandibular joint

EXCISION

21025 2 Excision of bone (eg, for osteomyelitis or bone abscess);
mandible

21026 2 Excision of bone (eg, for osteomyelitis or bone abscess);
facial bone(s)

21034 3 Excision of malignant tumor of facial bone other than
mandible

21040 2 Excision of benign cyst or tumor of mandible; simple

21041 2 Excision of benign cyst or tumor of mandible; complex

21044 2 Excision of malignant tumor of mandible

21050 3 Condylectomy, temporomandibular joint (separate procedure)

21060 2 Meniscectomy partial or complete, temporomandibular joint
(separate procedure)

21070 3 Coronoidectomy (separate procedure)

INTRODUCTION OR REMOVAL

21100 2 Application of halo type appliance for maxillofacial fixation,
includes removal (separate procedure)

REPAIR, REVISION, OR RECONSTRUCTION

21206 5 Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)

21208 7 Osteoplasty, facial bones; augmentation (autograft, allograft,
or prosthetic implant)

21209 5 Osteoplasty, facial bones; reduction

21210 7 Graft, bone; nasal, maxillary or malar areas (includes
obtaining graft)

21215 7 Graft, bone; mandible (includes obtaining graft)

21230 7 Graft; rib cartilage, autogenous, to face, chin, nose or ear
(includes obtaining graft)

21235 7 Graft; ear cartilage autograft, to nose or ear (includes
obtaining graft)

21240 4 Arthroplasty, temporomandibular joint, with or without
autograft (includes obtaining graft)

21242 5 Arthroplasty, temporomandibular joint, with allograft

21243 5 Arthroplasty, temporomandibular joint, with prosthetic joint
replacement

21244 7 Reconstruction of mandible, extraoral, with transosteal bone
plate (eg, mandibular staple bone plate)

21245 7 Reconstruction of mandible or maxilla, subperiosteal implant;
partial

21246 7 Reconstruction of mandible or maxilla, subperiosteal implant;
complete

21248 7 Reconstruction of mandible or maxilla, endosteal implant (eg
blade, cylinder); partial

21249 7 Reconstruction of mandible or maxilla, endosteal implant (eg
blade, cylinder); complete

21267 7 Orbital repositioning, periorbital osteotomies, unilateral,
with bone graft; extracranial approach

21270 5 Malar augmentation, prosthetic material

21275 7 Secondary revision of orbitocraniofacial reconstruction

21280 5 Medial canthopexy (separate procedure)

21282 5 Lateral canthopexy

FRACTURE AND/OR DISLOCATION

21300 2 Closed treatment of skull fracture without operation

21310 2 Closed treatment of nasal bone fracture without manipulation

21315	2	Closed treatment, nasal bone fracture; without stabilization
21320	2	Closed treatment, nasal bone fracture; with stabilization
21325	4	Open treatment of nasal fracture; uncomplicated
21330	5	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation
21335	7	Open treatment of nasal fracture; with concomitant open treatment of fractured septum
21337	2	Closed treatment of nasal septal fracture, with or without stabilization
21338	4	Open treatment of nasoethmoid fracture; without external fixation
21339	5	Open treatment of nasoethmoid fracture; with external fixation
21340	4	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
21343	5	Open treatment of depressed frontal sinus fracture
21355	3	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21360	4	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21365	5	Open treatment of complicated, (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches
21385	5	Open treatment of orbital floor "blowout" fracture; transantral approach (Caldwell-Luc type operation)
21386	5	Open treatment of orbital floor "blowout" fracture; periorbital approach
21387	5	Open treatment of orbital floor "blowout" fracture; combined approach
21390	7	Open treatment of orbital floor "blowout" fracture; periorbital approach, with alloplastic or other implant
21395	7	Open treatment of orbital floor "blowout" fracture; periorbital approach, with bone graft (includes obtaining graft)
21400	2	Closed treatment of fracture of orbit, except "blowout"; without manipulation
21401	3	Treatment of fracture of orbit, except "blowout"; with manipulation
21406	4	Open treatment of fracture of orbit, except "blowout"; without implant
21407	5	Open treatment of fracture of orbit, except "blowout"; with implant
21421	4	Closed treatment of palatal or maxillary fracture (LeFort I type); with interdental wire fixation or fixation of denture or splint
21422	5	Open treatment of palatal or maxillary fracture (LeFort I type)
21440	3	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445	4	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450	3	Closed treatment of mandibular fracture; without manipulation
21451	4	Closed treatment of mandibular fracture; with manipulation
21452	2	Percutaneous treatment of mandibular fracture, with external fixation
21453	3	Closed treatment of mandibular fracture, with interdental fixation
21454	5	Open treatment of mandibular fracture with external fixation

21461	4	Open treatment of mandibular fracture; without interdental fixation
21462	5	Open treatment of mandibular fracture; with interdental fixation
21465	4	Open treatment of mandibular condylar fracture
21470	5	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480	1	Closed treatment of temporomandibular dislocation, initial or subsequent
21485	2	Closed treatment of temporomandibular dislocation, initial or subsequent complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	3	Open treatment of temporomandibular dislocation
21493	3	Closed treatment of hyoid fracture; without manipulation
21494	4	Closed treatment of hyoid fracture; with manipulation
21495	4	Open treatment of hyoid fracture
21497	2	Interdental wiring, for condition other than fracture

NECK (SOFT TISSUES) AND THORAXINCISION

21501	2	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax
21502	2	Incision and drainage, deep abscess or hematoma; with partial rib osteotomy
21510	3	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax

EXCISION

21550	1	Biopsy, soft tissue of neck or thorax
21555	2	Excision tumor, soft tissue of neck or thorax; subcutaneous
21556	2	Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular
21600	2	Excision of rib, partial
21610	2	Costotransversectomy (separate procedure)
21620	2	Osteotomy of sternum, partial

REPAIR, REVISION OR RECONSTRUCTION

21700	2	Division of scalenus anticus; without resection of cervical rib
21720	3	Division of sternocleidomastoid for torticollis, open operation; without cast application
21725	3	Division of sternocleidomastoid for torticollis, open operation; with cast application

FRACTURE AND/OR DISLOCATION

21800	1	Closed treatment of rib fracture, uncomplicated, each
21805	2	Open treatment of rib fracture without fixation, each
21810	2	Treatment of rib fracture requiring external fixation ("flail chest")
21820	1	Closed treatment of sternum fracture

BACK AND FLANKEXCISION

21920	1	Biopsy, soft tissue of back or flank; superficial
21925	2	Biopsy, soft tissue of back or flank; deep
21930	2	Excision, tumor, soft tissue of back or flank

21935 3 Radial resection of tumor (eg, malignant neoplasm), soft tissue of back or flank

SPINE (VERTEBRAL COLUMN)

EXCISION

22100 3 Partial resection of vertebral component, spinous processes; cervical
22101 3 Partial resection of vertebral component, spinous processes; thoracic
22102 3 Partial resection of vertebral component, spinous processes; lumbar

FRACTURE AND/OR DISLOCATION

22305 1 Closed treatment of vertebral process fracture(s)
22310 1 Closed treatment of vertebral body fracture(s), without manipulation
22315 2 Closed treatment of vertebral fracture and/or dislocation, with or without anesthesia, by manipulation or traction, each
22325 3 Open treatment of vertebral fracture and/or dislocation; lumbar, each
22326 3 Open treatment of vertebral fracture and/or dislocation; cervical, each
22327 3 Open treatment of vertebral fracture and/or dislocation; thoracic, each

MANIPULATION

22505 2 Manipulation of spine requiring anesthesia, any region

ABDOMEN

EXCISION

22900 4 Excision, abdominal wall tumor, subfascial (eg, desmoid)

SHOULDER

INCISION

23000 2 Removal of subdeltoid (or intratendinous) calcareous deposits, open method
23020 2 Capsular contracture release (Sever type procedure) for Erb's palsy
23030 1 Incision and drainage, shoulder area; deep abscess or hematoma
23035 3 Incision, deep, with opening of cortex (eg, for osteomyelitis or bone abscess), shoulder area
23040 3 Arthrotomy, glenohumeral joint, for infection, with exploration, drainage or removal of foreign body
23044 4 Arthrotomy, acromioclavicular, sternoclavicular joint, for infection, with exploration, drainage or removal of foreign body

EXCISION

23065 1 Biopsy, soft tissue of shoulder area; superficial
23066 2 Biopsy, soft tissue of shoulder area; deep
23075 2 Excision, tumor, shoulder area; subcutaneous
23076 2 Excision, tumor shoulder area; deep, subfascial or intramuscular
23077 3 Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area

23100	2	Arthrotomy for biopsy, glenohumeral joint
23101	7	Arthrotomy for biopsy or for excision of torn cartilage, acromioclavicular, sternoclavicular joint
23105	4	Arthrotomy for synovectomy; glenohumeral joint
23106	4	Arthrotomy for synovectomy; sternoclavicular joint
23107	4	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
23120	5	Claviculectomy; partial
23125	5	Claviculectomy; total
23130	5	Acromioplasty or acromionectomy, partial
23140	4	Excision or curettage of bone cyst or benign tumor of clavicle or scapula
23145	5	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with autograft (includes obtaining graft)
23146	5	Excision or curettage of bone cyst or benign tumor of clavicle or scapula; with allograft
23150	4	Excision or curettage of bone cyst or benign tumor of proximal humerus
23155	5	Excision or curettage of bone cyst or benign tumor of proximal humerus; with autograft (includes obtaining graft)
23156	5	Excision or curettage of bone cyst or benign tumor of proximal humerus; with allograft
23170	2	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle;
23172	2	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula;
23174	2	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck
23180	4	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), clavicle
23182	4	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), scapula
23184	4	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), proximal humerus
23190	4	Ostectomy of scapula, partial (eg, superior medial angle)
23195	5	Resection humeral head

INTRODUCTION OR REMOVAL

23330	1	Removal of foreign body, shoulder; subcutaneous
23331	1	Removal of foreign body, shoulder; deep (eg, Neer prosthesis removal)

REPAIR, REVISION OR RECONSTRUCTION

23395	5	Muscle transfer, any type for paralysis of shoulder or upper arm; single
23397	7	Muscle transfer, any type for paralysis of shoulder or upper arm; multiple
23400	7	Scapulopexy (eg, Sprengel's deformity or for paralysis)
23405	2	Tenomyotomy, shoulder area; single
23406	2	Tenomyotomy, shoulder area; multiple through same incision
23410	5	Repair of ruptured supraspinatus tendon (rotator cuff) or musculotendinous cuff; acute
23412	7	Repair of ruptured supraspinatus tendon (rotator cuff) or musculotendinous cuff; chronic
23415	5	Coracoacromial ligament release, with or without acromioplasty
23420	7	Repair of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
23430	4	Tenodesis for rupture of long tendon of biceps

23440	4	Resection or transplantation of long tendon of biceps, for chronic tenosynovitis
23450	5	Capsulorrhaphy for recurrent dislocation, anterior; Putti-Platt procedure or Magnuson type operation
23455	7	Capsulorrhaphy for recurrent dislocation, anterior; Bankart type operation with or without stapling
23460	5	Capsulorrhaphy for recurrent dislocation, anterior, any type; with bone block
23462	7	Capsulorrhaphy for recurrent dislocation, anterior, any type; with coracoid process transfer
23465	5	Capsulorrhaphy for recurrent dislocation, posterior, with or without bone block
23466	7	Capsulorrhaphy for recurrent dislocation with any type multidirectional instability
23480	4	Osteotomy, clavicle, with or without internal fixation
23485	7	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)
23490	3	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle
23491	3	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus and humeral head
23500	1	Closed treatment of clavicular fracture; without manipulation
23505	1	Treatment of closed clavicular fracture; with manipulation
23515	3	Open treatment of clavicular fracture, with or without internal or external fixation
23520	1	Closed treatment of sternoclavicular dislocation; without manipulation

FRACTURE AND/OR DISLOCATION

23525	1	Treatment of closed sternoclavicular dislocation; with manipulation
23530	3	Open treatment of sternoclavicular dislocation, acute or chronic
23532	4	Open treatment of closed or open sternoclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)
23540	1	Closed treatment of acromioclavicular dislocation; without manipulation
23545	1	Treatment of closed acromioclavicular dislocation; with manipulation
23550	3	Open treatment of acromioclavicular dislocation, acute or chronic
23552	4	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)
23570	1	Closed treatment of scapular fracture; without manipulation
23575	1	Closed treatment of scapular fracture; with manipulation, with or without skeletal traction (with or without shoulder joint involvement)
23585	3	Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation
23600	1	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation

- 23605 2 Closed treatment of proximal humeral (surgical or anatomical neck) fracture; with manipulation, with or without skeletal fixation
- 23615 4 Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation with or without repair of tuberosity(-ies)
- 23616 4 Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(-ies); with proximal humeral prosthetic replacement
- 23620 1 Closed treatment of greater tuberosity fracture; without manipulation
- 23625 2 Closed treatment of greater tuberosity fracture; with manipulation
- 23630 5 Open treatment of greater tuberosity fracture, with or without internal or external fixation
- 23650 1 Closed treatment of shoulder dislocation, with manipulation; without anesthesia
- 23655 1 Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia
- 23660 3 Open treatment of acute shoulder dislocation
- 23665 2 Closed treatment of shoulder dislocation, with or without fracture of greater tuberosity, with manipulation
- 23670 3 Open treatment of shoulder dislocation, with fracture of greater tuberosity, with or without internal or external fixation
- 23675 2 Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation
- 23680 3 Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation

MANIPULATION

- 23700 1 Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)

ARTHRODESIS

- 23800 4 Arthrodesis, shoulder joint; with or without local bone graft
- 23802 7 Arthrodesis, shoulder joint; with primary autogenous graft (includes obtaining graft)

AMPUTATION

- 23921 3 Disarticulation of shoulder; secondary closure or scar revision

HUMERUS (UPPER ARM) AND ELBOWINCISION

- 23930 1 Incision and drainage, upper arm or elbow area; deep abscess or hematoma
- 23931 2 Incision and drainage, upper arm or elbow area; infected bursa
- 23935 2 Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess) humerus or elbow

EXCISION

- 24000 4 Arthrotomy, elbow, for infection, with exploration, drainage or removal of foreign body
- 24065 1 Biopsy, soft tissue of upper arm or elbow area; superficial
- 24066 2 Biopsy, soft tissue of upper arm or elbow area; deep
- 24075 2 Excision, tumor, upper arm or elbow area; subcutaneous

- | | | |
|-------|---|--|
| 24076 | 2 | Excision, tumor, upper arm or elbow area; deep, subfascial or intramuscular |
| 24077 | 3 | Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area |
| 24100 | 1 | Arthrotomy, elbow; for synovial biopsy only |
| 24101 | 4 | Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of loose or foreign body |
| 24102 | 4 | Arthrotomy, elbow; for synovectomy |
| 24105 | 3 | Excision, olecranon bursa |
| 24110 | 2 | Excision or curettage of bone cyst or benign tumor, humerus |
| 24115 | 3 | Excision or curettage of bone cyst or benign tumor, humerus; with autograft (includes obtaining graft) |
| 24116 | 3 | Excision or curettage of bone cyst or benign tumor, humerus; with allograft |
| 24120 | 3 | Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process |
| 24125 | 3 | Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with autograft (includes obtaining graft) |
| 24126 | 3 | Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with allograft |
| 24130 | 3 | Excision, radial head |
| 24134 | 2 | Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus |
| 24136 | 2 | Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck |
| 24138 | 2 | Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process |
| 24140 | 3 | Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis), humerus |
| 24145 | 3 | Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis), radial head or neck |
| 24147 | 2 | Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis), olecranon process |
| 24150 | 3 | Radical resection for tumor, shaft or distal humerus |
| 24151 | 4 | Radical resection for tumor, shaft or distal humerus; with autograft (includes obtaining graft) |
| 24152 | 3 | Radical resection for tumor, radial head or neck |
| 24153 | 4 | Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft) |
| 24155 | 3 | Resection of elbow joint (arthrectomy) |

INTRODUCTION OR REMOVAL

- | | | |
|-------|---|--|
| 24160 | 2 | Implant removal; elbow joint |
| 24164 | 3 | Implant removal; radial head |
| 24201 | 2 | Removal of foreign body, upper arm or elbow area; deep |

REPAIR, REVISION AND RECONSTRUCTION

- | | | |
|-------|---|---|
| 24301 | 4 | Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320-24331) |
| 24310 | 3 | Tenotomy, open, elbow to shoulder, single, each |
| 24320 | 3 | Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure) |
| 24330 | 3 | Flexor-plasty, elbow, (eg, Steindler type advancement) |

- 24331 3 Flexor-plasty, elbow, (eg, Steindler type advancement); with extensor advancement
- 24340 3 Tenodesis for rupture of biceps tendon at elbow
- 24342 3 Reinsertion of ruptured biceps tendon, distal, with or without tendon graft (includes obtaining graft)
- 24350 3 Fasciotomy, lateral or medial (eg, "tennis elbow" or epicondylitis)
- 24351 3 Fasciotomy, lateral or medial (eg, "tennis elbow" or epicondylitis); with extensor origin detachment
- 24352 3 Fasciotomy, lateral or medial (eg, "tennis elbow" or epicondylitis); with annular ligament resection
- 24354 3 Fasciotomy, lateral or medial (eg, "tennis elbow" or epicondylitis); with stripping
- 24356 3 Fasciotomy, lateral or medial (eg, "tennis elbow" or epicondylitis); with partial osteotomy
- 24360 5 Arthroplasty, elbow; with membrane
- 24361 5 Arthroplasty, elbow; with distal humeral prosthetic replacement
- 24362 5 Arthroplasty, elbow; with implant and fascia lata ligament reconstruction
- 24363 7 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement ("total elbow")
- 24365 5 Arthroplasty, radial head
- 24366 5 Arthroplasty, radial head; with implant
- 24400 4 Osteotomy, humerus, with or without internal fixation
- 24410 4 Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)
- 24420 3 Osteoplasty, humerus (eg, shortening or lengthening (excluding 64876))
- 24430 3 Repair of nonunion or malunion, humerus; without graft (eg, compression technique)
- 24435 4 Repair of nonunion or malunion, humerus; with iliac or other autograft (includes obtaining graft)
- 24470 3 Hemiepiphyseal arrest (eg, for cubitus varus or valgus, distal humerus)
- 24495 2 Decompression fasciotomy, forearm, with brachial artery exploration
- 24498 3 Prophylactic treatment (nailing, pinning, plating or wiring); with or without methylmethacrylate; humerus

FRACTURE AND/OR DISLOCATION

- 24500 1 Closed treatment of humeral shaft fracture; without manipulation
- 24505 1 Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal fixation
- 24515 4 Open treatment of humeral shaft fracture, with plate/screws, with or without cerclage
- 24516 4 Open treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
- 24530 1 Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension without manipulation
- 24535 1 Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; with manipulation, with or without skin or skeletal traction
- 24538 2 Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension

- 24545 4 Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension
- 24546 5 Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; with intercondylar extension
- 24560 1 Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation
- 24565 2 Closed treatment of humeral epicondylar fracture, medial or lateral; with manipulation
- 24566 2 Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
- 24575 3 Open treatment of humeral epicondylar fracture, medial or lateral; with or without internal or external fixation
- 24576 1 Closed treatment of humeral condylar fracture, medial or lateral; without manipulation
- 24577 1 Closed treatment of humeral condylar fracture, medial or lateral; with manipulation
- 24579 3 Open treatment of humeral condylar fracture, medial or lateral, with or without internal or external fixation
- 24582 2 Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation
- 24586 4 Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and and proximal ulna and/or proximal radius);
- 24587 5 Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius); with implant arthroplasty
- 24600 1 Treatment of closed elbow dislocation; without anesthesia
- 24605 2 Treatment of closed elbow dislocation; requiring anesthesia
- 24615 3 Open treatment of acute or chronic elbow dislocation
- 24620 2 Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation
- 24635 3 Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with or without internal or external fixation
- 24655 1 Closed treatment of radial head or neck fracture; with manipulation
- 24665 4 Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision
- 24666 4 Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision; with radial head prosthetic implant
- 24670 1 Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation
- 24675 1 Closed treatment of ulnar fracture, proximal end (olecranon process); with manipulation
- 24685 3 Open treatment of ulnar fracture proximal end (olecranon process), with or without internal or external fixation

ARTHRODESIS

- 24800 4 Arthrodesis, elbow joint; with or without local autograft or allograft
- 24802 5 Arthrodesis, elbow joint; with autograft (includes obtaining graft other than locally obtained)

AMPUTATION

24925 3 Amputation, arm through humerus; secondary closure or scar revision

FOREARM AND WRISTINCISION

25000 3 Tendon sheath incision; at radial styloid for deQuervain's disease
 25005 3 Tendon sheath incision; at wrist for other stenosing tenosynovitis
 25020 3 Decompression fasciotomy, forearm and/or wrist; flexor or extensor compartment
 25023 3 Decompression fasciotomy, forearm and/or wrist; with debridement of nonviable muscle and/or nerve
 25028 1 Incision and drainage, forearm and/or wrist; deep abscess or hematoma
 25031 2 Incision and drainage, forearm and/or wrist; infected bursa
 25035 2 Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), forearm and/or wrist
 25040 5 Arthrotomy, radiocarpal or mediocarpal joint, for infection, with exploration, drainage, or removal of foreign body

EXCISION

25065 1 Biopsy, soft tissue of forearm and/or wrist; superficial
 25066 2 Biopsy, soft tissue of forearm and/or wrist; deep
 25075 2 Excision, tumor, forearm and/or wrist area; subcutaneous
 25076 3 Excision, tumor, forearm and/or wrist area; deep, subfascial or intramuscular
 25077 3 Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area
 25085 3 Capsulotomy, wrist (eg, for contracture)
 25100 2 Arthrotomy, wrist joint; for biopsy
 25101 3 Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body
 25105 4 Arthrotomy, wrist joint; for synovectomy
 25107 3 Arthrotomy distal radioulnar joint for repair of triangular cartilage complex
 25110 3 Excision, lesion of tendon sheath, forearm and/or wrist
 25111 3 Excision of ganglion, wrist (dorsal or volar); primary
 25112 4 Excision of ganglion, wrist (dorsal or volar); recurrent
 25115 4 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors
 25116 4 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensor with or without transposition of dorsal retinaculum
 25118 2 Synovectomy, extensor tendon sheath, wrist, single compartment
 25119 3 Synovectomy, extensor tendon sheath, wrist, single compartment; with resection of distal ulna
 25120 3 Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process)
 25125 3 Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with primary autogenous graft (includes obtaining graft)
 25126 3 Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with allograft

25130	3	Excision or curettage of bone cyst or benign tumor of carpal bones
25135	3	Excision or curettage of bone cyst or benign tumor of carpal bones; with autograft
25136	3	Excision or curettage of bone cyst or benign tumor of carpal bones; with allograft
25145	2	Sequestrectomy (eg, for osteomyelitis or bone abscess); forearm and/or wrist
25150	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); ulna
25151	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); radius
25170	3	Radical resection for tumor, radius or ulna
25210	3	Carpectomy; one bone
25215	4	Carpectomy; all bones of proximal row
25230	4	Radial styloidectomy (separate procedure)
25240	4	Excision distal ulna (Darrach type procedure)

INTRODUCTION OR REMOVAL

25248	2	Exploration for removal of deep foreign body, forearm or wrist
25250	1	Removal of wrist prosthesis (separate procedure)
25251	1	Removal of wrist prosthesis; complicated, including "total wrist"

REPAIR, REVISION OR RECONSTRUCTION

25260	4	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
25263	2	Repair, tendon or muscle, flexor, forearm and/or wrist; secondary, single, each tendon or muscle
25265	3	Repair tendon or muscle, flexor, forearm and/or wrist; secondary, with free graft (includes obtaining graft), each tendon or muscle
25270	4	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle
25272	3	Repair, tendon or muscle, extensor, forearm and/or wrist; secondary, single, each tendon or muscle
25274	4	Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), forearm and/or wrist, each tendon or muscle
25280	4	Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single each tendon
25290	3	Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon
25295	3	Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon
25300	3	Tenodesis at wrist; flexors of fingers
25301	3	Tenodesis at wrist; extensors of fingers
25310	3	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon
25312	4	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; with tendon graft(s) (includes obtaining graft), each tendon
25315	3	Flexor origin slide for cerebral palsy, forearm and/or wrist
25316	3	Flexor origin slide for cerebral palsy, forearm and/or wrist; with tendon(s) transfer
25317	3	Flexor origin slide for Volkmann contracture
25318	3	Flexor origin slide for Volkmann contracture; with tendon(s) transfer

- 25320 3 Capsulorrhaphy or reconstruction, capsulectomy, wrist (includes synovectomy, resection of capsule, tendon insertions)
- 25330 5 Arthroplasty, wrist
- 25331 5 Arthroplasty, wrist; with implant
- 25332 5 Arthroplasty, wrist; pseudarthrosis type with internal fixation
- 25335 3 Centralization of wrist on ulna (eg, radial club hand)
- 25350 3 Osteotomy, radius; distal third
- 25355 3 Osteotomy, radius; middle or proximal third
- 25360 3 Osteotomy, ulna
- 25365 3 Osteotomy; radius and ulna
- 25370 3 Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna
- 25375 4 Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius AND ulna
- 25390 3 Osteoplasty, radius OR ulna; shortening
- 25391 4 Osteoplasty, radius OR ulna; lengthening with autograft
- 25392 3 Osteoplasty, radius AND ulna; shortening (excluding 64876)
- 25393 4 Osteoplasty, radius AND ulna; lengthening with autograft
- 25400 3 Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)
- 25405 4 Repair of nonunion or malunion, radius or ulna; with iliac or other autograft (includes obtaining graft)
- 25415 3 Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)
- 25420 4 Repair of nonunion or malunion, radius AND ulna; with iliac or other autograft (includes obtaining graft)
- 25425 3 Repair of defect with autograft; radius OR ulna
- 25426 4 Repair of defect with autograft; radius AND ulna
- 25440 4 Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)
- 25441 5 Arthroplasty with prosthetic replacement, distal radius
- 25442 5 Arthroplasty with prosthetic replacement, distal ulna
- 25443 5 Arthroplasty with prosthetic replacement, scaphoid (navicular)
- 25444 5 Arthroplasty with prosthetic replacement, lunate
- 25445 5 Arthroplasty with prosthetic replacement, trapezium
- 25446 7 Arthroplasty with prosthetic replacement, distal radius and partial or entire carpus ("total wrist")
- 25447 5 Interposition arthroplasty, intercarpal or carpometacarpal joints
- 25449 5 Revision of arthroplasty, including removal of implant, wrist joint
- 25450 3 Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna
- 25455 3 Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna
- 25490 3 Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate; radius
- 25491 3 Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate; ulna
- 25492 3 Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate; radius AND ulna

FRACTURE AND/OR DISLOCATION

- 25505 1 Closed treatment of radial shaft fracture; with manipulation
- 25515 3 Open treatment of radial shaft fracture, with or without internal or external fixation

- 25520 1 Closed treatment of radial shaft fracture, with dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)
- 25525 4 Open treatment of radial shaft fracture, with internal and/or external fixation and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation), with or without percutaneous skeletal fixation
- 25526 5 Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radioulnar (Galeazzi fracture/dislocation), includes repair of triangular cartilage
- 25535 1 Closed treatment of ulnar shaft fracture; with manipulation
- 25545 3 Open treatment of ulnar shaft fracture, with or without internal or external fixation
- 25565 2 Closed treatment of radial and ulnar shaft fractures; with manipulation
- 25574 3 Open treatment of radial and ulnar shaft fractures, with internal or external fixation; of radius or ulna
- 25575 3 Open treatment of radial and ulnar shaft fractures, with internal or external fixation; of radius and ulna
- 25605 3 Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation
- 25611 3 Percutaneous skeletal fixation of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation, with or without external fixation
- 25620 5 Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation
- 25624 2 Closed treatment of carpal scaphoid (navicular) fracture; with manipulation
- 25628 3 Open treatment of carpal scaphoid (navicular) fracture, with or without internal or external fixation
- 25635 1 Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone
- 25645 3 Open treatment of carpal bone fracture (excluding carpal scaphoid (navicular)), each bone
- 25660 1 Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation
- 25670 3 Open treatment of radiocarpal or intercarpal dislocation, one or more bones
- 25675 1 Closed treatment of distal radioulnar dislocation with manipulation
- 25676 2 Open treatment of distal radioulnar dislocation, acute or chronic
- 25680 2 Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation
- 25685 3 Open treatment of trans-scaphoperilunar type of fracture dislocation
- 25690 1 Closed treatment of lunate dislocation, with manipulation
- 25695 2 Open treatment of lunate dislocation

ARTHRODESIS

- 25800 4 Arthrodesis, wrist joint (including radiocarpal and/or ulnocarpal fusion); without bone graft
- 25805 5 Arthrodesis, wrist joint (including radiocarpal and/or ulnocarpal fusion); with sliding graft

- 25810 5 Arthrodesis, wrist joint (including radiocarpal and/or ulnocarpal fusion); with iliac or other autograft (includes obtaining graft)
 25820 4 Intercarpal fusion; without bone graft
 25825 5 Intercarpal fusion; with autograft (includes obtaining graft)

AMPUTATION

- 25907 3 Amputation, forearm, through radius and ulna; secondary closure or scar revision
 25922 3 Disarticulation through wrist; secondary closure or scar revision
 25929 3 Transmetacarpal amputation; secondary closure or scar revision

HANDS AND FINGERSINCISION

- 26011 1 Drainage of finger abscess; complicated (eg, felon, etc)
 26020 2 Drainage of tendon sheath, one digit and/or palm
 26025 1 Drainage of palmar bursa; single, ulnar or radial

ARTHRODESIS

- 26030 2 Drainage of palmar bursa; multiple or complicated
 26034 2 Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), hand or finger
 26035 4 Decompression fingers and/or hand, injection injury (eg, grease gun)
 26037 4 Decompression fasciotomy, hand (excludes 26035)
 26040 4 Fasciotomy, palmar, for Dupuytren's contracture; closed (subcutaneous)
 26045 3 Fasciotomy, palmar, for Dupuytren's contracture; open, partial
 26055 2 Tendon sheath incision for trigger finger
 26060 2 Tenotomy, subcutaneous, single, each digit
 26070 2 Arthrotomy, for infection, with exploration, drainage or removal of foreign body; carpometacarpal joint
 26075 4 Arthrotomy with exploration, drainage or removal of foreign body; metacarpophalangeal joint
 26080 4 Arthrotomy with exploration, drainage or removal of foreign body; interphalangeal joint, each

EXCISION

- 26100 2 Arthrotomy for synovial biopsy; carpometacarpal joint
 26105 1 Arthrotomy for synovial biopsy; metacarpophalangeal joint
 26110 1 Arthrotomy for synovial biopsy; interphalangeal joint, each
 26115 2 Excision, tumor or vascular malformation, tumor hand or finger; subcutaneous
 26116 2 Excision tumor or vascular malformation, hand or finger; deep, subfascial, intramuscular
 26117 3 Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger
 26121 4 Fasciectomy, palmar only, with or without z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)
 26123 4 Fasciectomy, palmar, with or without z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); partial palmar excision with release of single digit including proximal interphalangeal joint

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| 26125 | 4 | Fasciectomy, palmar, with or without z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); partial palmar excision with release of each additional digit, including proximal interphalangeal joint |
| 26130 | 3 | Synovectomy, carpometacarpal joint |
| 26135 | 4 | Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit |
| 26140 | 2 | Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint |
| 26145 | 3 | Synovectomy tendon sheath, radical (tenosynovectomy), flexor, palm or finger, single, each digit |
| 26160 | 3 | Excision of lesion of tendon sheath or capsule (eg, cyst, mucous cyst or ganglion), hand or finger |
| 26170 | 3 | Excision of tendon, palm, flexor, single (separate procedure), each |
| 26180 | 3 | Excision of tendon, finger, flexor (separate procedure) |
| 26200 | 2 | Excision or curettage of bone cyst or benign tumor of metacarpal |

26205	3	Excision or curettage of bone cyst or benign tumor of metacarpal; with autogenous graft (includes obtaining graft)
26210	2	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx of finger
26215	3	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx of finger; with autograft
26230	7	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); metacarpal
26235	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); proximal or middle phalanx of finger
26236	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); distal phalanx of finger
26250	3	Radical resection (ostectomy) for tumor, metacarpal
26255	3	Radical resection (ostectomy) for tumor, metacarpal; with autograft (includes obtaining graft)
26260	3	Radical resection (ostectomy) for tumor, proximal or middle phalanx of finger
26261	3	Radical resection (ostectomy) for tumor, proximal or middle phalanx of finger; with autograft (includes obtaining graft)
26262	2	Radical resection (ostectomy) for tumor, distal phalanx of finger

INTRODUCTION OR REMOVAL

26320	2	Removal of implant from finger or hand
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REPAIR, REVISION OR RECONSTRUCTION

26350	1	Flexor tendon repair or advancement, single, not in "no man's land"; primary or secondary without free graft, each tendon
26352	4	Flexor tendon repair or advancement, single, not in "no man's land"; secondary with free graft (includes obtaining graft), each tendon
26356	4	Flexor tendon repair or advancement, single, in "no man's land"; primary, each tendon
26357	4	Flexor tendon repair or advancement, single, in "no man's land"; secondary, each tendon
26358	4	Flexor tendon repair or advancement, single, in "no man's land"; secondary with free graft (includes obtaining graft), each tendon
26370	4	Profundus tendon repair or advancement, with intact sublimis; primary
26372	4	Profundus tendon repair or advancement, with intact sublimis; secondary with free graft (includes obtaining graft)
26373	3	Profundus tendon repair or advancement, with intact sublimis; secondary without free graft
26390	4	Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft, hand or finger
26392	3	Removal of tube or rod and insertion of flexor tendon graft (includes obtaining graft), hand or finger
26410	3	Extensor tendon repair, dorsum of hand, single, primary or secondary; without free graft, each tendon
26412	3	Extensor tendon repair, dorsum of hand, single, primary or secondary; with free graft (includes obtaining graft), each tendon
26415	4	Extensor tendon excision, implantation of plastic tube or rod for delayed extensor tendon graft, hand or finger
26418	4	Extensor tendon repair, dorsum of finger, single, primary or secondary; without free graft, each tendon

26420	4	Extensor tendon repair, dorsum of finger, single, primary or secondary; with free graft (includes obtaining graft), each tendon
26426	3	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); using local tissues
26428	3	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); with free graft (includes obtaining graft)
26432	3	Extensor tendon repair, distal insertion ("mallet finger"), closed, splinting with or without percutaneous pinning
26433	3	Extensor tendon repair, distal insertion ("mallet finger"), open, primary or secondary repair; without graft
26434	3	Extensor tendon repair, distal insertion ("mallet finger") open, primary or secondary repair; with free graft (includes obtaining graft)
26437	3	Extensor tendon realignment, hand
26440	3	Tenolysis, simple, flexor tendon; palm OR finger, single, each tendon
26442	3	Tenolysis, simple, flexor tendon; palm AND finger, each tendon
26445	3	Tenolysis, extensor tendon, dorsum of hand or finger; each tendon
26449	3	Tenolysis, complex, extensor tendon, dorsum of hand or finger, including hand and forearm
26450	3	Tenotomy, flexor, single, palm, open, each
26455	3	Tenotomy, flexor, single, finger, open, each
26460	3	Tenotomy, extensor, hand or finger, single, open, each
26471	2	Tenodesis; for proximal interphalangeal joint stabilization
26474	2	Tenodesis; for distal joint stabilization
26476	1	Tendon lengthening, extensor, hand or finger single, each
26477	1	Tendon shortening, extensor, hand or finger single, each
26478	1	Tendon lengthening, flexor, hand or finger, single, each
26479	1	Tendon shortening, flexor, hand or finger, single, each
26480	3	Tendon transfer or transplant, carpometacarpal area or dorsum of hand, single; without free graft, each
26483	3	Tendon transfer or transplant, carpometacarpal area or dorsum of hand, single; with free tendon graft (includes obtaining graft), each tendon
26485	2	Tendon transfer or transplant, palmar, single, each tendon; without free tendon graft
26489	3	Tendon transfer or transplant, palmar, single, each tendon; with free tendon graft (includes obtaining graft), each tendon
26490	3	Opponens plasty; sublimis tendon transfer type
26492	3	Opponens plasty; tendon transfer with graft (includes obtaining graft)
26494	3	Opponens plasty; hypothenar muscle transfer
26496	3	Opponens plasty; other methods
26497	3	Tendon transfer to restore intrinsic function; ring and small finger
26498	4	Tendon transfer to restore intrinsic function; all four fingers
26499	3	Correction claw finger, other methods
26500	4	Tendon pulley reconstruction; with local tissues (separate procedure)
26502	4	Tendon pulley reconstruction; with tendon or fascial graft (includes obtaining graft) (separate procedure)
26504	4	Tendon pulley reconstruction; with tendon prosthesis (separate procedure)
26508	3	Thenar muscle release for thumb contracture
26510	3	Cross intrinsic transfer

26516	1	Capsulodesis for M-P joint stabilization; single digit
26517	3	Capsulodesis for M-P joint stabilization; two digits
26518	3	Capsulodesis for M-P joint stabilization; three or four digits
26520	3	Capsulectomy or capsulotomy for contracture; metacarpophalangeal joint, single, each
26525	3	Capsulectomy or capsulotomy for contracture; interphalangeal joint, single, each
26527	5	Arthroplasty, carpometacarpal joint
26530	3	Arthroplasty, metacarpophalangeal joint; single, each
26531	7	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, single, each
26535	5	Arthroplasty interphalangeal joint; single, each
26536	5	Arthroplasty interphalangeal joint; with prosthetic implant, single, each
26540	4	Primary repair of collateral ligament, metacarpophalangeal joint
26541	7	Reconstruction, collateral ligament, metacarpophalangeal joint; with tendon or fascial graft (includes obtaining graft)
26542	4	Primary repair of collateral ligament, metacarpophalangeal joint; with local tissue (eg, adductor advancement)
26545	4	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint
26548	4	Repair and reconstruction, finger, volar plate, interphalangeal joint
26550	2	Pollicization of a digit
26552	4	Reconstruction thumb with toe
26555	3	Positional change of other finger
26557	3	Toe to finger transfer; first stage
26558	2	Toe to finger transfer; each delay
26559	2	Toe to finger transfer; second stage
26560	2	Repair of syndactyly (web finger) each web space; with skin flaps
26561	3	Repair of syndactyly (web finger) each web space; with skin flaps and grafts
26562	4	Repair of syndactyly (web finger) each web space; complex (eg, involving bone, nails)
26565	5	Osteotomy for correction of deformity; metacarpal
26567	5	Osteotomy for correction of deformity; phalanx of finger
26568	3	Osteoplasty for lengthening of metacarpal or phalanx
26580	5	Repair cleft hand
26585	5	Repair bifid digit
26590	5	Repair macrodactylia
26591	3	Repair, intrinsic muscles of hand (specify)
26593	3	Release, intrinsic muscles of hand (specify)
26596	2	Excision of constricting ring of finger, with multiple Z-plasties
26597	3	Release of scar contracture, flexor or extensor, with skin grafts, rearrangement flaps, or Z-plasties, hand and/or finger

FRACTURES AND/OR DISLOCATIONS

26605	2	Closed treatment of metacarpal fracture, single; with manipulation, each bone
26607	2	Closed treatment of metacarpal fracture, with manipulation, with internal or external fixation, each bone
26615	4	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone

- 26645 1 Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
- 26650 2 Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation; with or without external fixation
- 26665 4 Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation
- 26675 2 Closed treatment of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation; requiring anesthesia
- 26676 2 Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation
- 26685 3 Open treatment of carpometacarpal dislocation, other than thumb (Bennett fracture); single, with or without internal or external fixation
- 26686 3 Open treatment of carpometacarpal dislocation, other than thumb (Bennett fracture); complex, multiple or delayed reduction
- 26705 2 Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
- 26706 2 Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation
- 26715 4 Open treatment of metacarpophalangeal dislocation, single, with or without internal or external fixation
- 26727 7 Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
- 26735 4 Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each
- 26742 2 Closed treatment of articular fracture, involving metacarpophalangeal or proximal interphalangeal joint; with manipulation, each
- 26746 5 Open treatment of articular fracture, involving metacarpophalangeal or proximal interphalangeal joint with or without external fixation, each
- 26756 2 Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb; each
- 26765 4 Open treatment of distal phalangeal fracture, finger or thumb, with or without external fixation, each
- 26776 2 Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation
- 26785 2 Open treatment of interphalangeal joint dislocation with or without external fixation, single

ARTHRODESIS

- 26820 5 Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)
- 26841 4 Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation
- 26842 4 Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autograft (includes obtaining graft)
- 26843 3 Arthrodesis, carpometacarpal joint, digits, other than thumb
- 26844 3 Arthrodesis, carpometacarpal joint, digits, other than thumb; with autograft (includes obtaining graft)
- 26850 4 Arthrodesis, metacarpophalangeal joint, with or without internal fixation

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| 26852 | 4 | Arthrodesis, metacarpophalangeal joint, with or without internal fixation; with autograft (includes obtaining graft) |
| 26860 | 3 | Arthrodesis, interphalangeal joint, with or without internal fixation |
| 26861 | 2 | Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint |
| 26862 | 4 | Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft) |
| 26863 | 3 | Arthrodesis, interphalangeal joint, with or without internal fixation; with autograft (includes obtaining graft), each additional joint |

AMPUTATION

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| 26910 | 3 | Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseus transfer |
| 26951 | 2 | Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure |
| 26952 | 4 | Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood) |

PELVIS AND HIP JOINTINCISION

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| 26990 | 1 | Incision and drainage, pelvis or hip joint area; deep abscess or hematoma |
| 26991 | 1 | Incision and drainage, pelvis or hip joint area; infected bursa |
| 26992 | 2 | Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), pelvis and/or hip joint |
| 27000 | 2 | Tenotomy, adductor of hip, subcutaneous, closed (separate procedure) |
| 27001 | 3 | Tenotomy, adductor of hip, subcutaneous, open |
| 27003 | 3 | Tenotomy, adductor, subcutaneous, open, with obturator neurectomy |
| 27030 | 3 | Arthrotomy, hip, for infection, with drainage |
| 27033 | 3 | Arthrotomy, hip, for exploration or removal of loose or foreign body |
| 27035 | 4 | Hip joint denervation, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or obturator nerves |

EXCISION

- | | | |
|-------|---|---|
| 27040 | 1 | Biopsy, soft tissue of pelvis and hip area; superficial |
| 27041 | 2 | Biopsy, soft tissue of pelvis and hip area; deep |
| 27047 | 2 | Excision, tumor, pelvis and hip area; subcutaneous |
| 27048 | 3 | Excision, tumor, pelvis and hip area; deep, subfascial, intramuscular |
| 27049 | 3 | Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area |
| 27050 | 3 | Arthrotomy, for biopsy; sacroiliac joint |
| 27052 | 3 | Arthrotomy, for biopsy; hip joint |
| 27060 | 5 | Excision; ischial bursa |
| 27062 | 5 | Excision; trochanteric bursa or calcification |
| 27065 | 5 | Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autograft |
| 27066 | 5 | Excision of bone cyst or benign tumor; deep, with or without autograft |
| 27080 | 2 | Coccygectomy, primary |

PRODUCTION AND/OR REMOVAL

- | | | |
|-------|---|---|
| 27086 | 1 | Removal of foreign body, pelvis or hip; subcutaneous tissue |
| 27087 | 3 | Removal of foreign body, pelvis or hip; deep |

REPAIR, REVISION OR RECONSTRUCTION

- | | | |
|-------|---|--|
| 27097 | 3 | Hamstring recession, proximal |
| 27098 | 3 | Adductor transfer to ischium |
| 27100 | 4 | Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft) |
| 27105 | 4 | Transfer paraspinous muscle to hip (includes fascial or tendon extension graft) |
| 27110 | 4 | Transfer iliopsoas; to greater trochanter |
| 27111 | 4 | Transfer iliopsoas; to femoral neck |

FRACTURES AND/OR DISLOCATIONS

- | | | |
|-------|---|--|
| 27193 | 1 | Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation |
| 27194 | 2 | Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia |
| 27202 | 2 | Open treatment of coccygeal fracture |
| 27230 | 1 | Closed treatment of femoral fracture, proximal end, neck; without manipulation |
| 27238 | 1 | Closed treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; without manipulation |
| 27246 | 1 | Closed treatment of greater trochanteric fracture, without manipulation |
| 27250 | 1 | Closed treatment of hip dislocation, traumatic; without anesthesia |
| 27252 | 2 | Treatment of closed hip dislocation, traumatic; requiring anesthesia |
| 27265 | 1 | Closed treatment of post hip arthroplasty dislocation; without anesthesia |
| 27266 | 2 | Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia |

MANIPULATION

- | | | |
|-------|---|---|
| 27275 | 2 | Manipulation, hip joint, requiring general anesthesia |
|-------|---|---|

FEMUR (THIGH REGION) AND KNEE JOINTINCISION

- | | | |
|-------|---|--|
| 27301 | 3 | Incision and drainage of deep abscess, infected bursa, or hematoma, thigh or knee region |
| 27303 | 2 | Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), femur or knee |
| 27305 | 2 | Fasciotomy, iliotibial (tenotomy), open |
| 27306 | 3 | Tenotomy, subcutaneous, closed, adductor or hamstring, (separate procedure); single |
| 27307 | 3 | Tenotomy, subcutaneous, closed, adductor or hamstring, (separate procedure); multiple |
| 27310 | 4 | Arthrotomy, knee, for infection, with exploration, drainage or removal of foreign body |
| 27315 | 2 | Neurectomy, hamstring muscle |
| 27320 | 2 | Neurectomy, popliteal (gastrocnemius) |

EXCISION

- | | | |
|-------|---|--|
| 27323 | 1 | Biopsy, soft tissue of thigh or knee area; superficial |
| 27324 | 1 | Biopsy, soft tissue of thigh or knee area; deep |

27327	2	Excision, tumor, thigh or knee area; subcutaneous
27328	3	Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular
27330	4	Arthrotomy, knee; for synovial biopsy only
27331	4	Arthrotomy, knee with joint exploration, with or without biopsy, with or without removal of loose or foreign bodies
27332	4	Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medial OR lateral
27333	4	Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medial AND lateral
27334	4	Arthrotomy, knee, for synovectomy; anterior OR posterior
27335	4	Arthrotomy, knee, for synovectomy; anterior AND posterior including popliteal area
27340	3	Excision, prepatellar bursa
27345	4	Excision of synovial cyst of popliteal space (Baker's cyst)
27350	4	Patellectomy or hemipatellectomy
27355	3	Excision or curettage of bone cyst or benign tumor of femur
27356	4	Excision or curettage of bone cyst or benign tumor of femur; with allograft
27360	5	Partial excision (craterization, saucerization or diaphysectomy) of bone, (eg, for osteomyelitis), femur, proximal tibia and/or fibula

INTRODUCTION AND/OR REMOVAL

27372	7	Removal of foreign body, deep, thigh region or knee area
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REPAIR, REVISION OR RECONSTRUCTION

27380	1	Suture of infrapatellar tendon; primary
27381	3	Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft
27385	3	Suture of quadriceps or hamstring muscle rupture; primary
27386	3	Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft
27390	1	Tenotomy, open, hamstring, knee to hip; single
27391	2	Tenotomy, open, hamstring, knee to hip; multiple, one leg
27392	3	Tenotomy, open, hamstring, knee to hip; multiple, bilateral
27393	2	Lengthening of hamstring tendon; single
27394	3	Lengthening of hamstring tendon; multiple, one leg
27395	3	Lengthening of hamstring tendon; multiple, bilateral
27396	3	Transplant, hamstring tendon to patella; single
27397	3	Transplant, hamstring tendon to patella; multiple
27400	3	Tendon or muscle transfer, hamstrings to femur (Eggers type procedure)
27403	4	Arthrotomy with open meniscus repair
27405	4	Repair, primary, torn ligament and/or capsule, knee; collateral
27407	4	Repair, primary, torn ligament and/or capsule, knee; cruciate
27409	4	Repair, primary, torn ligament and/or capsule, knee; collateral and cruciate ligaments
27418	3	Anterior tibial tubercle plasty for chondromalacia patellae (Haquet procedure)
27420	3	Reconstruction for recurrent dislocating patella; (Hauser type procedure)
27422	7	Reconstruction for recurrent dislocating patella; with extensor realignment and/or muscle advancement or release (Campbell, Goldwaite type procedure)
27424	3	Reconstruction for recurrent dislocating patella; with patellectomy
27425	7	Lateral retinacular release (any method)

27427	3	Ligamentous reconstruction (augmentation), knee; extra-articular
27428	4	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
27429	4	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
27430	4	Quadriceps plasty (Bennett or Thompson type)
27435	4	Capsulotomy, knee, posterior capsular release
27437	4	Arthroplasty, patella; without prosthesis
27438	5	Arthroplasty, patella; with prosthesis
27440	5	Arthroplasty, knee, tibial plateau
27441	5	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
27442	5	Arthroplasty, knee, femoral condyles or tibial plateaus
27443	5	Arthroplasty, knee, femoral condyles or tibial plateaus; with debridement and partial synovectomy

FRACTURES AND/OR DISLOCATIONS

27500	1	Closed treatment of femoral shaft fracture, without manipulation
27501	2	Closed treatment of supracondylar or trancondylar femoral fracture with or without intercondylar extension, without manipulation
27502	2	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction
27503	3	Closed treatment of supracondylar or trancondylar femoral fracture with or without intercondylar extension; with manipulation, with or without skin or skeletal traction
27507	4	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage
27508	1	Closed treatment of femoral fracture, distal end, medial or lateral condyle; without manipulation
27509	3	Percutaneous skeletal fixation of supracondylar or trancondylar femoral fracture, with or without intercondylar extension
27510	1	Closed treatment of femoral fracture, distal end, medial or lateral condyle; with manipulation
27511	4	Open treatment of femoral supracondylar or trancondylar fracture without intercondylar extension, with or without internal or external fixation
27513	5	Open treatment of femoral supracondylar or trancondylar fracture with intercondylar extension, with or without internal or external fixation
27516	1	Closed treatment of distal femoral epiphyseal separation; without manipulation
27517	1	Closed treatment of distal femoral epiphyseal separation; with manipulation, with or without skin or skeletal traction
27520	1	Closed treatment of patellar fracture, without manipulation
27524	3	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair
27530	1	Closed treatment of tibial fracture, proximal (plateau); without manipulation
27532	1	Closed treatment of tibial fracture, proximal (plateau); with or without manipulation, with skeletal traction
27535	3	Open treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation
27538	1	Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
27550	1	Closed treatment of knee dislocation; without anesthesia

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|-------|---|---|
| 27552 | 1 | Closed treatment of knee dislocation; requiring anesthesia |
| 27560 | 1 | Closed treatment of patellar dislocation; without anesthesia |
| 27562 | 1 | Closed treatment of patellar dislocation; requiring anesthesia |
| 27566 | 2 | Open treatment of patellar dislocation, with or without partial or total patellectomy |

MANIPULATION

- | | | |
|-------|---|--|
| 27570 | 1 | Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices) |
|-------|---|--|

LEG (TIBIA AND FIBULA) AND ANKLE JOINTINCISION

- | | | |
|-------|---|---|
| 27603 | 2 | Incision and drainage, leg or ankle; deep abscess or hematoma |
| 27604 | 2 | Incision and drainage, leg or ankle; infected bursa |
| 27605 | 1 | Tenotomy, Achilles tendon, subcutaneous (separate procedure); local anesthesia |
| 27606 | 1 | Tenotomy, Achilles tendon, subcutaneous (separate procedure); general anesthesia |
| 27607 | 2 | Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), leg or ankle |
| 27610 | 2 | Arthrotomy, ankle, for infection with exploration, drainage or removal of foreign body |
| 27612 | 3 | Arthrotomy, ankle, posterior capsular release, with or without Achilles tendon lengthening |

EXCISION

- | | | |
|-------|---|--|
| 27613 | 1 | Biopsy, soft tissue of leg or ankle area; superficial |
| 27614 | 2 | Biopsy, soft tissue of leg or ankle area; deep |
| 27615 | 3 | Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area |
| 27618 | 2 | Excision, tumor, leg or ankle area; subcutaneous |
| 27619 | 3 | Excision, tumor, leg or ankle area; deep, subfascial or intramuscular |
| 27620 | 4 | Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body |
| 27625 | 4 | Arthrotomy, ankle, for synovectomy |
| 27626 | 4 | Arthrotomy, ankle, for synovectomy; including tenosynovectomy |
| 27630 | 3 | Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle |
| 27635 | 3 | Excision or curettage of bone cyst or benign tumor, tibia or fibula |
| 27637 | 3 | Excision or curettage of bone cyst, or benign tumor, tibia or fibula; with autograft (includes obtaining graft) |
| 27638 | 3 | Excision or curettage of bone cyst, or benign tumor, tibia or fibula; with primary homogenous graft |
| 27640 | 2 | Partial excision (craterization, saucerization, or diaphysectomy) of bone, (eg, for osteomyelitis or exostosis); tibia |
| 27641 | 2 | Partial excision (craterization, saucerization, or diaphysectomy) of bone, (eg, for osteomyelitis exostosis); fibula |

REPAIR, REVISION OR RECONSTRUCTION

- | | | |
|-------|---|---|
| 27650 | 3 | Repair, primary, open or percutaneous, ruptured Achilles tendon |
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- 27652 3 Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)
- 27654 3 Repair, secondary, ruptured Achilles tendon, with or without graft
- 27656 2 Repair, fascial defect of leg
- 27658 1 Repair or suture of flexor tendon of leg; primary, without graft, single, each
- 27659 2 Repair or suture of flexor tendon of leg; secondary, with or without graft, single tendon, each
- 27664 2 Repair or suture of extensor tendon of leg; primary, without graft, single, each
- 27665 2 Repair or suture of extensor tendon of leg; secondary with or without graft, single tendon, each
- 27675 2 Repair for dislocating peroneal tendons; without fibular osteotomy
- 27676 3 Repair for dislocating peroneal tendons; with fibular osteotomy
- 27680 3 Tenolysis, including tibia, fibula and ankle flexor; single
- 27681 2 Tenolysis, including tibia, fibula and ankle flexor; multiple (through same incision), each
- 27685 3 Lengthening or shortening of tendon leg or ankle; single (separate procedure)
- 27686 3 Lengthening or shortening of tendon; multiple (through same incision), each
- 27687 3 Gastrocnemius recession (eg, Strayer procedure)
- 27690 4 Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)
- 27691 4 Transfer or transplant of single tendon (with muscle redirection or rerouting); anterior tibial or posterior tibial through interosseous space
- 27692 3 Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon
- 27695 2 Suture, primary, torn, ruptured or severed ligament, ankle; collateral
- 27696 2 Suture, primary, torn, ruptured or severed ligament, ankle; both collateral ligaments
- 27698 2 Suture, secondary repair, torn, ruptured or severed ligament, ankle, collateral (eg, Watson-Jones procedures)
- 27700 5 Arthroplasty, ankle
- 27704 2 Removal of ankle implant
- 27705 2 Osteotomy; tibia
- 27707 2 Osteotomy; fibula
- 27709 2 Osteotomy; tibia and fibula
- 27715 4 Osteoplasty, tibia and fibula, lengthening
- 27730 2 Epiphyseal arrest by epiphysiodesis or stapling; distal tibia
- 27732 2 Epiphyseal arrest by epiphysiodesis or stapling; distal fibula
- 27734 2 Epiphyseal arrest by epiphysiodesis or stapling; distal tibia and fibula
- 27740 2 Epiphyseal arrest by epiphysiodesis or stapling; combined, proximal and distal tibia and fibula
- 27742 2 Epiphyseal arrest by epiphysiodesis or stapling; combined, proximal and distal tibia and fibula and distal femur
- 27745 3 Prophylactic treatment (nailing, pinning, plating or wiring); with or without methylmethacrylate, tibia

FRACTURES AND/OR DISLOCATIONS

- 27750 1 Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation

- 27752 1 Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal fixation
- 27756 3 Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture)(eg, pins or screws)
- 27758 4 Open treatment of tibial shaft fracture, (with or without fibular fracture) with plates/screws, with or without cerclage
- 27759 4 Open treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage
- 27760 1 Closed treatment of medial malleolus fracture; without manipulation
- 27762 1 Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction
- 27766 3 Open treatment of medial malleolus fracture, with or without internal or external fixation
- 27780 1 Closed treatment of proximal fibula or shaft fracture; without manipulation
- 27781 1 Closed treatment of proximal fibula or shaft fracture; with manipulation
- 27784 3 Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation
- 27786 1 Closed treatment of distal fibular fracture (lateral malleolus); without manipulation
- 27788 1 Closed treatment of distal fibular fracture (lateral malleolus); with manipulation
- 27792 3 Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation
- 27808 1 Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation
- 27810 1 Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation
- 27814 3 Open treatment of bimalleolar ankle fracture, with or without internal or external fixation
- 27816 1 Closed treatment of trimalleolar ankle fracture; without manipulation
- 27818 1 Closed treatment of trimalleolar ankle fracture; with manipulation
- 27822 3 Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip
- 27823 3 Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; with fixation of posterior lip
- 27824 1 Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation
- 27825 2 Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation
- 27826 3 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of fibula only
- 27827 3 Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of tibia only

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|-------|---|--|
| 27828 | 4 | Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal or external fixation; of both tibia and fibula |
| 27829 | 2 | Open treatment of distal tibiofibular joint (syndesmosis) disruption, with or without internal or external fixation |
| 27830 | 1 | Closed treatment of proximal tibiofibular joint dislocation; without anesthesia |
| 27831 | 1 | Closed treatment of proximal tibiofibular joint dislocation; requiring anesthesia |
| 27832 | 2 | Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula |
| 27840 | 1 | Closed treatment of ankle dislocation; without anesthesia |
| 27842 | 1 | Closed treatment of ankle dislocation; requiring anesthesia, with or without percutaneous skeletal fixation |
| 27846 | 3 | Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or external fixation |
| 27848 | 3 | Open treatment of ankle dislocation with or without percutaneous skeletal fixation; with repair or internal fixation |

MANIPULATION

- | | | |
|-------|---|---|
| 27860 | 1 | Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus) |
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ARTHRODESIS

- | | | |
|-------|---|---|
| 27870 | 4 | Arthrodesis, ankle, any method |
| 27871 | 4 | Arthrodesis, tibiofibular joint, proximal or distal |

AMPUTATION

- | | | |
|-------|---|--|
| 27884 | 3 | Amputation leg, through tibia and fibula; secondary closure or scar revision |
|-------|---|--|

FOOTINCISION

- | | | |
|-------|---|--|
| 28002 | 3 | Deep dissection below fascia, for deep infection of foot with or without tendon sheath involvement; single bursal space, specify |
| 28003 | 3 | Deep dissection below fascia, for deep infection of foot with or without tendon sheath involvement; multiple areas |
| 28005 | 3 | Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), foot |
| 28008 | 3 | Fasciotomy, foot and/or toe |
| 28020 | 2 | Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint |
| 28030 | 4 | Neurectomy of intrinsic musculature of foot |
| 28035 | 4 | Tarsal tunnel release (posterior tibial nerve decompression) |

EXCISION

- | | | |
|-------|---|--|
| 28043 | 2 | Excision, tumor, foot; subcutaneous |
| 28045 | 3 | Excision, tumor, foot; deep, subfascial, intramuscular |
| 28046 | 3 | Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot |
| 28050 | 2 | Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint |

28054	2	Arthrotomy for synovial biopsy; interphalangeal joint
28060	2	Fasciectomy, excision of plantar fascia; partial (separate procedure)
28062	3	Fasciectomy, excision of plantar fascia; radical (separate procedure)
28070	3	Synovectomy; intertarsal or tarsometatarsal joint, each
28072	3	Synovectomy; metatarsophalangeal joint, each
28080	3	Excision of interdigital (Morton) neuroma, single, each
28086	2	Synovectomy, tendon sheath, foot; flexor
28088	2	Synovectomy, tendon sheath, foot; extensor
28090	3	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot
28092	3	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); toes
28100	2	Excision or curettage of bone cyst or benign tumor, talus or calcaneus
28102	3	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)
28103	3	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft
28104	2	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus
28106	3	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)
28107	3	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus; with allograft
28110	3	Osteotomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
28111	3	Osteotomy, complete excision; first metatarsal head
28112	3	Osteotomy, complete excision; other metatarsal head (second, third, or fourth)
28113	3	Osteotomy, complete excision; fifth metatarsal head
28114	3	Osteotomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (Clayton type procedure)
28116	3	Osteotomy, excision of tarsal coalition
28118	4	Osteotomy, calcaneus
28119	4	Osteotomy, calcaneus; for spur, with or without plantar fascial release

28120	7	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (e.g., for osteomyelitis or talar bossing), talus or calcaneus
28122	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or tarsal bossing), tarsal or metatarsal bone, except talus or calcaneus
28130	3	Talectomy (astragalectomy)
28140	3	Metatarsectomy
28150	3	Phalangectomy of toe, single, each
28171	3	Radical resection for tumor; tarsal (except talus or calcaneus)
28173	3	Radical resection for tumor; metatarsal
28175	3	Radical resection for tumor; phalanx of toe

INTRODUCTION AND/OR REMOVAL

28192	2	Removal of foreign body, foot; deep
28193	4	Removal of foreign body, foot; complicated

REPAIR, REVISION OR RECONSTRUCTION

28200	3	Repair or suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon
28202	3	Repair or suture of tendon, foot, flexor, single; secondary with free graft, each tendon (includes obtaining graft)
28208	3	Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon
28210	3	Repair or suture of tendon, foot, extensor, single; secondary with free graft, each tendon (includes obtaining graft)
28222	1	Tenolysis, flexor foot; multiple (through same incision)
28225	1	Tenolysis, extensor foot; single
28226	1	Tenolysis, extensor foot; multiple (through same incision)
28236	2	Transfer of tendon, anterior tibial into tarsal bone
28238	3	Advancement of posterior tibial tendon with excision of accessory navicular bone (Kidner type procedure)
28240	2	Tenotomy, lengthening, or release, abductor hallucis muscle
28250	3	Division of plantar fascia and muscle ("Steindler stripping") (separate procedure)
28260	3	Capsulotomy, midfoot; medial release only (separate procedure)
28261	3	Capsulotomy, midfoot; with tendon lengthening
28262	4	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity
28264	1	Capsulotomy, midtarsal (Heyman type procedure)
28280	2	Webbing operation (create syndactylism of toes) for soft corn (Kelikian type procedure)
28285	3	Hammer toe operation; one toe (eg, interphalangeal fusion, filleting, phalangectomy)
28286	4	Hammer toe operation; for cock-up fifth toe with plastic skin closure, (Ruiz-Mora type procedure)
28288	3	Osteotomy, partial, exostectomy or condylectomy, single, metatarsal head, first through fifth, each metatarsal head
28290	2	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)
28292	2	Hallux valgus (bunion) correction, with or without sesamoidectomy; Keller, McBride or Mayo type procedure
28293	3	Hallux valgus (bunion) correction, with or without sesamoidectomy; resection of joint with implant

28294	3	Hallux valgus (bunion) correction, with or without sesamoidectomy; with tendon transplants (Joplin type procedure)
28296	3	Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)
28297	3	Hallux valgus (bunion) correction, with or without sesamoidectomy; Lapidus type procedure
28298	3	Hallux valgus (bunion) correction with or without sesamoidectomy; by phalanx osteotomy
28299	5	Hallux valgus (bunion) correction with or without sesamoidectomy; by other methods (eg, double osteotomy)
28300	2	Osteotomy; calcaneus (Dwyer or Chambers type procedure) with or without internal fixation
28302	2	Osteotomy; talus
28304	2	Osteotomy, midtarsal bones, other than calcaneus or talus
28305	3	Osteotomy, midtarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (Fowler type)
28306	4	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; first metatarsal
28308	2	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; other than first metatarsal
28309	4	Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)
28310	3	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312	3	Osteotomy for shortening, angular or rotational correction; other phalanges, any toe
28313	2	Reconstruction, angular deformity of toe (overlapping second toe, fifth toe, curly toes), soft tissue procedures only
28315	4	Sesamoidectomy, first toe (separate procedure)
28320	4	Repair of nonunion or malunion; tarsal bones (calcaneus, talus, etc)
28322	4	Repair of nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)

FRACTURE AND/OR DISLOCATION

28400	1	Closed treatment of calcaneal fracture; without manipulation
28405	2	Closed treatment of calcaneal fracture; with manipulation
28406	2	Percutaneous skeletal fixation of calcaneal fracture, with manipulation
28415	3	Open treatment of calcaneal fracture, with or without internal or external fixation
28420	4	Open treatment of calcaneal fracture, with or without internal or external fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)
28435	2	Closed treatment of talus fracture; with manipulation
28436	2	Percutaneous skeletal fixation of talus fracture; with manipulation
28445	3	Open treatment of talus fracture, with or without internal or external fixation
28465	3	Open treatment of tarsal bone fracture (except talus and calcaneus), with or without internal or external fixation, each
28476	2	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each

28485	4	Open treatment of metatarsal fracture, with or without internal or external fixation, each
28496	2	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges; with manipulation
28505	3	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation
28525	3	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, each
28545	1	Closed treatment of tarsal bone dislocation other than talotarsal; requiring anesthesia
28546	2	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation
28555	2	Open treatment of tarsal bone dislocation, with or without internal or external fixation
28575	1	Closed treatment of talotarsal joint dislocation; requiring anesthesia
28576	3	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
28585	3	Open treatment of talotarsal joint dislocation, with or without internal or external fixation
28605	1	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia
28606	2	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation
28615	3	Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation
28635	1	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia
28636	3	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
28645	3	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation
28665	1	Closed treatment of interphalangeal joint dislocation; requiring anesthesia
28666	3	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation
28675	3	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation

ARTHRODESIS

28705	4	Pantalar arthrodesis
28715	4	Triple arthrodesis
28725	4	Subtalar arthrodesis
28730	4	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse
28735	4	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy as for flatfoot correction
28737	5	Arthrodesis, midtarsal navicular-cuneiform, with tendon lengthening and advancement (Miller type procedure)
28740	4	Arthrodesis, midtarsal or tarsometatarsal, single joint
28750	4	Arthrodesis, great toe; metatarsophalangeal joint
28755	4	Arthrodesis, great toe; interphalangeal joint
28760	4	Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)

AMPUTATION

28810	2	Amputation, metatarsal, with toe, single
28820	2	Amputation, toe; metatarsophalangeal joint
28825	2	Amputation, toe; interphalangeal joint

ARTHROSCOPY

- 29815 3 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
- 29819 3 Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
- 29820 3 Arthroscopy, shoulder, surgical; synovectomy, partial
- 29821 3 Arthroscopy, shoulder, surgical; synovectomy, complete
- 29822 3 Arthroscopy, shoulder, surgical; debridement, limited
- 29823 3 Arthroscopy, shoulder, surgical; debridement, extensive
- 29825 3 Arthroscopy, shoulder, surgical; with lysis and resection of adhesions with or without manipulation
- 29826 3 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty with or without coracoclavicular release
- 29830 3 Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
- 29834 3 Arthroscopy, elbow, surgical; with removal of loose body or foreign body
- 29835 3 Arthroscopy, elbow, surgical; synovectomy, partial
- 29836 3 Arthroscopy, elbow, surgical; synovectomy, complete
- 29837 3 Arthroscopy, elbow, surgical; debridement, limited
- 29838 3 Arthroscopy, elbow, surgical; debridement, extensive
- 29840 3 Arthroscopy wrist, diagnostic, with or without synovial biopsy (separate procedure)
- 29843 3 Arthroscopy, wrist, surgical; for infection, lavage and drainage
- 29844 3 Arthroscopy, wrist, surgical; synovectomy, partial
- 29845 3 Arthroscopy, wrist, surgical; synovectomy, complete
- 29846 3 Arthroscopy, wrist, surgical; excision of triangular fibrocartilage and/or joint debridement
- 29847 3 Arthroscopy, wrist, surgical; internal fixation for fracture or instability
- 29850 4 Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
- 29851 4 Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)
- 29855 4 Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (includes arthroscopy)
- 29856 4 Arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal or external fixation (includes arthroscopy)
- 29870 3 Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
- 29871 3 Arthroscopy, knee, surgical; for infection, lavage and drainage
- 29874 3 Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)
- 29875 4 Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection) (separate procedure)
- 29876 4 Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (e.g., medial or lateral)
- 29877 4 Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

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| 29879 | 3 | Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling |
| 29880 | 4 | Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) |
| 29881 | 4 | Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral including any meniscal shaving) |
| 29882 | 3 | Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral) |
| 29883 | 3 | Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral) |
| 29884 | 3 | Arthroscopy, knee, surgical; with lysis of adhesions with or without manipulation (separate procedure) |
| 29885 | 3 | Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting; with or without internal fixation (including debridement of base of lesion) |
| 29886 | 3 | Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion |

29887 3	Arthroscopy, knee surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
29888 3	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889 3	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
29894 3	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895 3	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial
29897 3	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited
29898 3	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive

RESPIRATORY SYSTEMNOSEEXCISION

30115 2	Excision, nasal polyp(s), extensive
30117 3	Excision or destruction, any method (including laser) intranasal lesion; internal approach
30118 3	Excision or destruction, intranasal lesion; external approach (lateral rhinotomy)
30120 1	Excision or surgical planing of skin of nose for rhinophyma
30124 1	Excision dermoid cyst, nose; simple, skin, subcutaneous
30125 2	Excision dermoid cyst, nose; complex, under bone or cartilage
30130 3	Excision turbinate, partial or complete
30140 2	Submucous resection turbinate, partial or complete
30150 3	Rhinectomy; partial
30160 4	Rhinectomy; total

REMOVAL FOREIGN BODY

30310 1	Removal foreign body, intranasal; requiring general anesthesia
30320 2	Removal foreign body; by lateral rhinotomy

REPAIR

30400 4	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410 5	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420 5	Rhinoplasty, primary; including major septal repair
30430 3	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435 5	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450 7	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30520 4	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540 5	Repair choanal atresia; intranasal
30560 2	Lysis intranasal synechia
30580 4	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600 4	Repair fistula; oronasal

- 30620 7 Septal or other intranasal dermatoplasty (does not include obtaining graft)
 30630 7 Repair nasal septal perforations
 30801 1 Cauterization and/or ablation, mucosa of turbinates, unilateral or bilateral, any method, (separate procedure); superficial
 30802 1 Cauterization and/or ablation, mucosa of turbinates, unilateral or bilateral, any method, (separate procedure); intramural

OTHER PROCEDURES

- 30903 1 Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
 30905 1 Control nasal hemorrhage, posterior, with posterior nasal packs and/or cauterization any method; initial
 30906 1 Control nasal hemorrhage, posterior, with posterior nasal packs and/or cauterization; subsequent
 30915 2 Ligation arteries; ethmoidal
 30920 3 Ligation arteries; internal maxillary artery, transantral

ACCESSORY SINUSESINCISION

- 31020 2 Sinusotomy, maxillary (antrotomy); intranasal
 31030 3 Sinusotomy, maxillary (antrotomy); radical, (Caldwell-Luc) without removal of antrochoanal polyps
 31032 4 Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps
 31050 2 Sinusotomy, sphenoid, with or without biopsy
 31051 4 Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s)
 31070 2 Sinusotomy frontal; external, simple (trephine operation)
 31075 4 Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)
 31080 4 Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)
 31086 4 Sinusotomy frontal; nonobliterative, with osteoplastic flap, brow incision
 31090 5 Sinusotomy combined, three or more sinuses

EXCISION

- 31200 2 Ethmoidectomy; intranasal, anterior
 31201 5 Ethmoidectomy; intranasal, total
 31205 3 Ethmoidectomy; extranasal, total

ENDOSCOPY

- 31233 2 Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
 31235 1 Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)
 31237 2 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
 31238 1 Nasal/sinus endoscopy, surgical; with control of epistaxis
 31239 4 Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy
 31240 2 Nasal/sinus endoscopy, surgical; with concha bullosa resection
 31245 3 Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s);
 31246 3 Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with antrostomy

- 31247 3 Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with antrostomy and removal of antral mucosal disease
- 31248 3 Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with frontal sinus exploration
- 31249 3 Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with frontal sinus exploration and antrostomy
- 31251 3 Nasal/sinus endoscopy, surgical, with osteomeatal complex (OMC) resection and/or anterior ethmoidectomy, with or without removal of polyp(s); with frontal sinus exploration, antrostomy, and removal of antral mucosal disease
- 31261 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s);
- 31262 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with antrostomy
- 31264 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with antrostomy and removal of antral mucosal disease
- 31266 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with frontal sinus exploration
- 31269 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with frontal sinus exploration and antrostomy
- 31271 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy (APE), with or without removal of polyp(s); with frontal sinus exploration, antrostomy, and removal of antral mucosal disease
- 31280 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s);
- 31281 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with antrostomy
- 31282 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with antrostomy and removal of antral mucosal disease
- 31283 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with frontal sinus exploration
- 31284 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with frontal sinus exploration and antrostomy
- 31286 5 Nasal/sinus endoscopy, surgical, with anterior and posterior ethmoidectomy and sphenoidotomy (APS), with or without removal of polyp(s); with frontal sinus exploration, antrostomy and removal of antral mucosal disease
- 31287 3 Nasal/sinus endoscopy, surgical, with sphenoidotomy;
- 31288 3 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus

LARYNXEXCISION

- 31300 5 Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy
 31320 2 Laryngotomy (thyrotomy, laryngofissure); diagnostic

ENDOSCOPY

- 31510 2 Laryngoscopy, indirect (separate procedure); with biopsy
 31511 2 Laryngoscopy, indirect (separate procedure); with removal of foreign body
 31512 2 Laryngoscopy, indirect (separate procedure); with removal of lesion
 31513 2 Laryngoscopy, indirect (separate procedure); with vocal cord injection
 31515 1 Laryngoscopy direct, with or without tracheoscopy; for aspiration
 31525 1 Laryngoscopy, direct, with or without tracheoscopy; diagnostic, except newborn
 31526 2 Laryngoscopy, direct, with or without tracheoscopy; diagnostic, with operating microscope
 31527 1 Laryngoscopy, direct, with or without tracheoscopy; with insertion of obturator
 31528 2 Laryngoscopy direct, with or without tracheoscopy; with dilation, initial
 31529 2 Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent
 31530 2 Laryngoscopy, direct, operative, with foreign body removal
 31531 3 Laryngoscopy, direct, operative, with foreign body removal; with operating microscope
 31535 2 Laryngoscopy, direct, operative, with biopsy
 31536 3 Laryngoscopy, direct, operative, with biopsy; with operating microscope
 31540 3 Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis
 31541 4 Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope
 31560 5 Laryngoscopy, direct, operative, with arytenoidectomy
 31561 5 Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope
 31570 2 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic
 31571 2 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope
 31576 2 Laryngoscopy, flexible fiberoptic; with biopsy
 31577 2 Laryngoscopy, flexible fiberoptic; with removal of foreign body
 31578 2 Laryngoscopy, flexible fiberoptic; with removal of lesion
 31580 5 Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal
 31582 5 Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy
 31584 4 Laryngoplasty; with open reduction of fracture

- 31585 1 Treatment of closed laryngeal fracture; without manipulation
 31586 2 Treatment of closed laryngeal fracture; with closed manipulative reduction
 31588 5 Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)
 31590 5 Laryngeal reinnervation by neuromuscular pedicle

DESTRUCTION

- 31595 2 Section recurrent laryngeal nerve, therapeutic (separate procedure), unilateral

TRACHEA AND BRONCHIINCISION

- 31600 2 Tracheostomy, planned (separate procedure)
 31611 3 Construction of tracheopharyngeal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)
 31612 1 Tracheal puncture, percutaneous for aspiration of mucus (transtracheal aspiration)
 31613 2 Tracheostoma revision; simple, without flap rotation
 31614 2 Tracheostoma revision; complex, with flap rotation

ENDOSCOPY

- 31615 1 Tracheobronchoscopy through established tracheostomy incision
 31622 1 Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing
 31625 2 Bronchoscopy; with biopsy
 31628 2 Bronchoscopy; with transbronchial lung biopsy, with or without fluoroscopic guidance
 31629 2 Bronchoscopy; with transbronchial needle aspiration biopsy
 31630 2 Bronchoscopy; with tracheal or bronchial dilation or closed reduction of fracture
 31631 2 Bronchoscopy; with tracheal dilation and placement of tracheal stent
 31635 2 Bronchoscopy; with removal of foreign body
 31640 2 Bronchoscopy; with excision of tumor
 31641 2 Bronchoscopy; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser)
 31645 1 Bronchoscopy; with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)
 31646 1 Bronchoscopy; with therapeutic aspiration of tracheobronchial tree, subsequent
 31656 1 Bronchoscopy; with injection of contrast material for segmental bronchography (fiberscope only)
 31659 1 Bronchoscopy; with other bronchoscopic procedures

INTRODUCTION

- 31700 1 Catheterization, transglottic (separate procedure)
 31710 1 Catheterization for bronchography, with or without instillation of contrast material
 31715 1 Transtracheal injection for bronchography
 31717 1 Catheterization with bronchial brush biopsy
 31720 1 Catheter aspiration (separate procedure); nasotracheobronchial

- 31730 1 Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy

REPAIR

- 31750 5 Tracheoplasty; cervical
31755 2 Tracheoplasty; tracheopharyngeal fistulization, each stage
31765 4 Excision of tracheal tumor or carcinoma; cervical

SUTURE

- 31800 2 Suture of external tracheal wound or injury; cervical
31820 1 Surgical closure tracheostomy or fistula; without plastic repair
31825 2 Surgical closure tracheostomy or fistula; with plastic repair
31830 2 Revision of tracheostomy scar

LUNGS AND PLEURAINCISION

- 32000 1 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent
32002 2 Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure)
32005 2 Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)
32020 2 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

EXCISION

- 32400 1 Biopsy, pleura; percutaneous needle
32405 1 Biopsy, lung or mediastinum, percutaneous needle
32420 1 Pneumonocentesis, puncture of lung for aspiration

CARDIOVASCULAR SYSTEMHEART AND PERICARDIUMPERICARDIUM

- 33010 2 Pericardiocentesis; initial
33011 2 Pericardiocentesis; subsequent

ARTERIES AND VEINSARTERIAL EMBOLECTOMY OR THROMBECTOMY

- 34101 3 Embolectomy or thrombectomy, with or without catheter, axillary, brachial, innominate, subclavian artery, by arm incision

INTRA-ARTERIAL--INTRA-AORTIC

- 36261 2 Revision of implanted intra-arterial infusion pump
36262 1 Removal of implanted intra-arterial infusion pump

VENOUS

- 36489 1 Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure hyperalimentation, hemodialysis or chemotherapy); percutaneous, cutaneous, over age 2
36491 1 Placement of entral venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); cutdown, over age 2

36522 2	Photopheresis, extracorporeal
36530 3	Insertion of implantable intravenous infusion pump
36531 2	Revision of implantable intravenous infusion pump
36532 1	Removal of implantable intravenous infusion pump
36533 3	Insertion of implantable venous access port, with or without subcutaneous reservoir
36534 2	Revision of implantable venous access port and/or subcutaneous reservoir
36535 1	Removal of implantable venous access port and/or subcutaneous reservoir

ARTERIAL

36640 1	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
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INTERVASCULAR CANNULIZATION OR SHUNT (SEPARATE PROCEDURE)

36800 3	Insertion of cannula for hemodialysis, other purpose; vein to vein
36810 3	Insertion of cannula for hemodialysis, other purpose; arteriovenous, external (Scribner type)
36815 3	Insertion of cannula for hemodialysis, other purpose; arteriovenous, external revision or closure
36821 3	Arteriovenous anastomosis, direct, any site
36825 4	Creation of arteriovenous fistula; autogenous graft
36830 4	Creation of arteriovenous fistula; nonautogenous graft
36832 4	Revision of an arteriovenous fistula, with or without thrombectomy, autogenous or nonautogenous graft
36835 4	Insertion of Thomas shunt
36840 4	Insertion mandril
36845 4	Anastomosis mandril
36860 2	Cannula declotting; without balloon catheter
36861 3	Cannula declotting; with balloon catheter

LIGATION AND OTHER PROCEDURES

37609 2	Ligation or biopsy, temporal artery
37700 2	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37720 3	Ligation and division and complete stripping of long or short saphenous veins
37730 3	Ligation and division and complete stripping of long and short saphenous veins
37735 3	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
37760 3	Ligation of perforators, subfascial, radical (Linton Type), with or without skin graft
37780 3	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
37785 3	Ligation, division and/or excision of recurrent or secondary varicose veins (clusters), one leg

HEMIC AND LYMPHATIC SYSTEMLYMPH NODES AND LYMPHATIC CHANNELS

INCISION

- 38300 1 Drainage of lymph node abscess or lymphadenitis; simple
 38305 2 Drainage of lymph node abscess or lymphadenitis; extensive
 38308 2 Lymphangiectomy or other operations on lymphatic channels

EXCISION

- 38500 2 Biopsy or excision of lymph node(s); superficial (separate procedure)
 38505 1 Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)
 38510 2 Biopsy or excision of lymph node(s); deep cervical node(s)
 38520 2 Biopsy or excision of lymph node(s); deep cervical node(s) with excision scalene fat pad
 38525 2 Biopsy or excision of lymph node(s); deep axillary node(s)
 38530 2 Biopsy or excision of lymph node(s); internal mammary node(s) (separate procedure)
 38542 2 Dissection; deep jugular node(s)
 38550 3 Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection; simple
 38555 4 Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection; complex

RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

- 38700 2 Suprahyoid lymphadenectomy
 38740 2 Axillary lymphadenectomy; superficial
 38745 4 Axillary lymphadenectomy; complete
 38760 2 Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure)

INTRODUCTION

- 38790 1 Injection procedure for lymphangiography

DIGESTIVE SYSTEMLIPSEXCISION

- 40500 2 Vermilionectomy (lip shave), with mucosal advancement
 40510 2 Excision of lip; transverse wedge excision with primary closure
 40520 2 Excision of lip; V-excision with primary direct linear closure
 40525 2 Excision of lip; full thickness, reconstruction with local flap (Estlander or fan)
 40527 2 Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
 40530 2 Resection of lip, more than one-fourth, without reconstruction

REPAIR (CHEILOPLASTY)

- 40650 3 Repair lip, full thickness; vermilion only
 40652 3 Repair lip, full thickness; up to half vertical height
 40654 3 Repair lip, full thickness; over one half vertical height, or complex

VESTIBULE OF MOUTH

INCISION

40801	2	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
40805	2	Removal of embedded foreign body; complicated
40806	1	Incision of labial frenum (frenotomy)

EXCISION, DESTRUCTION

40814	2	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair
40816	2	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle
40818	1	Excision of mucosa of vestibule of mouth as donor graft
40819	1	Excision of frenum, labial or buccal (frenulectomy, frenulectomy, frenectomy)
40820	1	Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)

REPAIR

40831	1	Closure of laceration, vestibule of mouth; over 2.5 cm or complex
40840	2	Vestibuloplasty; anterior
40842	3	Vestibuloplasty; posterior, unilateral
40843	3	Vestibuloplasty; posterior, bilateral
40844	5	Vestibuloplasty; entire arch
40845	5	Vestibuloplasty; complex (including ridge extension, muscle repositioning)

TONGUE, FLOOR OF MOUTHINCISION

41000	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial
41006	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid
41007	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space
41008	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space
41009	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space
41010	1	Incision of lingual frenum (frenotomy)
41015	1	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	1	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental
41017	1	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular
41018	1	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space

EXCISION

41105	2	Biopsy of tongue; posterior one-third
41110	1	Excision of lesion of tongue without closure
41112	2	Excision of lesion of tongue with closure; anterior two-thirds
41113	2	Excision of lesion of tongue with closure; posterior one-third

41114	2	Excision of lesion of tongue with closure; with local tongue flap
41115	1	Excision of lingual frenum (frenectomy)
41116	1	Excision, lesion of floor of mouth
41120	5	Glossectomy; less than one-half tongue

REPAIR

41250	2	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue
41251	2	Repair of laceration 2.5 cm or less; posterior one-third of tongue
41252	2	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex

OTHER PROCEDURES

41500	1	Fixation of tongue, mechanical, other than suture (eg, K-wire)
41510	1	Suture of tongue to lip for micrognathia (Douglas type procedure)
41520	2	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)

DENTOALVEOLAR STRUCTURESINCISION

41800	1	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	1	Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806	1	Removal of embedded foreign body from dentoalveolar structures; bone

EXCISION, DESTRUCTION

41827	2	Excision of lesion or tumor (except listed above) dentoalveolar structures; with complex repair
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PALATE, UVULAINCISION

42000	2	Drainage of abscess of palate, uvula
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EXCISION, DESTRUCTION

42104	2	Excision, lesion of palate, uvula; without closure
42106	2	Excision, lesion of palate, uvula; with simple primary closure
42107	2	Excision, lesion of palate, uvula; with local flap closure
42120	4	Resection of palate or extensive resection of lesion
42140	2	Uvulectomy, excision of uvula
42145	5	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42160	1	Destruction of lesion, palate or uvula (thermal, cryo or chemical)

REPAIR

42180	1	Repair, laceration of palate; up to 2 cm
42182	2	Repair, laceration of palate; over 2 cm or complex
42200	5	Palatoplasty for cleft palate, soft and/or hard palate only
42205	5	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210	5	Palatoplasty for cleft palate, with closure of alveolar ridge;

- 42215 7 with bone graft to alveolar ridge (includes obtaining graft)
- 42220 5 Palatoplasty for cleft palate; major revision
- 42225 5 Palatoplasty for cleft palate; secondary lengthening procedure
- 42235 5 Palatoplasty for cleft palate; attachment pharyngeal flap
- 42260 4 Repair of anterior palate, including vomer flap
- 42281 3 Repair of nasolabial fistula
- 42281 3 Insertion of pin-retained palatal prosthesis

SALIVARY GLAND AND DUCTSINCISION

- 42300 1 Drainage of abscess; parotid, simple
- 42305 2 Drainage of abscess; parotid, complicated
- 42310 1 Drainage of abscess; submaxillary or sublingual, intraoral
- 42320 1 Drainage of abscess; submaxillary, external
- 42325 2 Fistulization of sublingual salivary cyst (ranula)
- 42335 3 Sialolithotomy; submandibular (submaxillary), complicated, intraoral
- 42340 2 Sialolithotomy; parotid, extraoral or complicated intraoral

EXCISION

- 42405 2 Biopsy of salivary gland; incisional
- 42408 3 Excision of sublingual salivary cyst (ranula)
- 42409 3 Marsupialization of sublingual salivary cyst (ranula)
- 42410 3 Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
- 42420 7 Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve
- 42425 7 Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve
- 42440 3 Excision of submandibular (submaxillary) gland
- 42450 2 Excision of sublingual gland

REPAIR

- 42500 3 Plastic repair of salivary duct, sialodochoplasty; primary or simple
- 42505 4 Plastic repair of salivary duct, sialodochoplasty; secondary or complicated
- 42507 3 Parotid duct diversion, bilateral (Wilke type procedure)
- 42508 4 Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland
- 42509 4 Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands
- 42510 4 Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both submandibular (Wharton's) ducts

OTHER PROCEDURES

- 42600 1 Closure salivary fistula

PHARYNX, ADENOIDS, AND TONSILSINCISION

- 42700 1 Incision and drainage abscess; peritonsillar
- 42720 1 Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach
- 42725 2 Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach

EXCISION, DESTRUCTION

- 42802 1 Biopsy; hypopharynx
- 42804 1 Biopsy; nasopharynx, visible lesion, simple
- 42806 2 Biopsy; nasopharynx, survey for unknown primary lesion
- 42808 2 Excision or destruction of lesion of pharynx, any method
- 42810 3 Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
- 42815 5 Excision branchial cleft cyst, vestige or fistula, extending beneath subcutaneous tissues and/or into pharynx
- 42821 5 Tonsillectomy and adenoidectomy; age 12 or over
- 42826 4 Tonsillectomy, primary or secondary, age 12 or over
- 42831 4 Adenoidectomy, primary; age 12 or over
- 42836 4 Adenoidectomy, secondary; age 12 or over
- 42860 3 Excision of tonsil tags
- 42870 3 Excision or destruction lingual tonsil any method (separate procedure)
- 42880 5 Excision nasopharyngeal lesion (eg, fibroma)

REPAIR

- 42900 1 Suture pharynx for wound or injury
- 42950 2 Pharyngoplasty (plastic or reconstructive operation on pharynx)

OTHER PROCEDURES

- 42955 2 Pharyngostomy (fistulization of pharynx, external for feeding)
- 42960 1 Control oropharyngeal hemorrhage, primary or secondary (eg, posttonsillectomy); simple
- 42962 2 Control oropharyngeal hemorrhage, primary or secondary (eg, posttonsillectomy); with secondary surgical intervention

ESOPHAGUSENDOSCOPY

- 43200 1 Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 43202 1 Esophagoscopy, rigid or flexible; with biopsy, single or multiple
- 43204 1 Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices
- 43215 1 Esophagoscopy, rigid or flexible; with removal of foreign body
- 43216 1 Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 43217 1 Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- 43219 1 Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent
- 43220 1 Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)
- 43226 1 Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire
- 43227 2 Esophagoscopy, rigid or flexible; with control of bleeding, any method
- 43228 2 Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- 43234 1 Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)
- 43235 1 Upper gastrointestinal endoscopy including esophagus, stomach,

- and either the duodenum and/or jejunum as appropriate; complex diagnostic with or without collection of specimen(s) by brushing or washing (separate procedure)
- 43239 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy single or multiple
- 43241 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic tube or catheter placement
- 43243 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices
- 43245 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction any method
- 43246 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube
- 43247 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body
- 43250 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 43251 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 43255 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method
- 43258 3 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- 43260 2 Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 43261 2 Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
- 43262 2 Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy
- 43263 2 Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of oddi (pancreatic duct or common bile duct)
- 43264 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of stone(s) from biliary and/or pancreatic ducts
- 43265 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction lithotripsy of stones, any method
- 43267 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube
- 43268 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct

- 43269 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube, or stent
- 43271 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)
- 43272 2 Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

MANIPULATION

- 43450 1 Dilation of esophagus, by unguided sound or bougie, single or multiple passes
- 43453 1 Dilation of esophagus, over guide wire
- 43456 2 Dilation of esophagus by balloon or dilators; retrograde
- 43458 2 Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia

STOMACHEXCISION

- 43600 1 Biopsy of stomach; by capsule, tube, peroral (one or more specimens)

INTRODUCTION

- 43750 2 Percutaneous placement of gastrostomy tube
- 43760 1 Change of gastrostomy tube

SUTURE

- 43870 1 Closure of gastrostomy, surgical

INTESTINES (EXCEPT RECTUM)EXCISION

- 44100 1 Biopsy of intestine by capsule, tube, peroral (one or more specimens)

ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES

- 44312 1 Revision of ileostomy; simple (release of superficial scar) (separate procedure)
- 44340 3 Revision of colostomy; simple (release of superficial scar) (separate procedure)
- 44345 4 Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)
- 44346 4 Revision of colostomy; with repair of paracolostomy hernia (separate procedure)

ENDOSCOPY, SMALL BOWEL AND STOMAL

- 44360 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 44361 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple
- 44363 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum not including ileum; with removal of foreign body

- 44364 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- 44365 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 44366 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding, any method
- 44369 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- 44372 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; with placement of percutaneous jejunostomy tube
- 44373 2 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube
- 44380 1 Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 44382 1 Ileoscopy, through stoma; with biopsy, single or multiple
- 44385 1 Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 44386 1 Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple
- 44388 1 Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 44389 1 Colonoscopy through stoma; with biopsy, single or multiple
- 44390 1 Fiberoptic colonoscopy through colostomy; with removal of foreign body
- 44391 1 Colonoscopy through stoma; with control of bleeding, any method
- 44392 1 Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 44393 1 Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- 44394 1 Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

RECTUMINCISION

- 45000 1 Transrectal drainage of pelvic abscess
- 45005 2 Incision and drainage of submucosal abscess, rectum
- 45020 2 Incision and drainage of deep supralelevator, pelvirectal, or retrorectal abscess

EXCISION

- 45100 1 Biopsy of anorectal wall, anal approach (eg, congenital megacolon)
- 45108 2 Anorectal myomectomy
- 45150 1 Division of stricture of rectum
- 45170 2 Excision of rectal tumor, transanal approach

- 45180 2 Excision and/or electrodesiccation of malignant tumor of rectum, transanal approach

ENDOSCOPY

- 45305 1 Proctosigmoidoscopy, rigid; with biopsy, single or multiple
 45307 1 Proctosigmoidoscopy, with removal of foreign body
 45308 1 Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
 45309 1 Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
 45315 1 Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
 45317 1 Proctosigmoidoscopy, rigid; with control of bleeding, any method
 45320 1 Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)
 45321 1 Proctosigmoidoscopy rigid; with decompression of volvulus
 45331 1 Sigmoidoscopy, flexible; with biopsy, single or multiple
 45332 1 Sigmoidoscopy, flexible; with removal of foreign body
 45333 1 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
 45334 1 Sigmoidoscopy, flexible; with control of bleeding, any method
 45337 1 Sigmoidoscopy, flexible; with decompression of volvulus, any method
 45338 1 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
 45339 1 Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
 45355 1 Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
 45378 2 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
 45379 2 Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
 45380 2 Colonoscopy, fiberoptic, proximal to splenic flexure; with biopsy, single or multiple
 45382 2 Colonoscopy, fiberoptic, proximal to splenic flexure; with control of bleeding, any method
 45383 2 Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
 45384 2 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
 45385 2 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

REPAIR

- 45500 2 Proctoplasty; for stenosis
 45505 2 Proctoplasty; for prolapse of mucous membrane
 45560 2 Repair of rectocele (separate procedure)

MANIPULATION

- 45900 1 Reduction of procidentia (separate procedure) under anesthesia

- 45905 1 Dilation of anal sphincter (separate procedure) under anesthesia other than local
 45910 1 Dilation of rectal stricture (separate procedure) under anesthesia other than local
 45915 1 Removal of fecal impaction or foreign body (separate procedure) under anesthesia

ANUSINCISION

- 46030 1 Removal of anal seton, other marker
 46040 3 Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
 46045 2 Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia
 46050 1 Incision and drainage, perianal abscess, superficial
 46060 2 Incision and drainage of ischiorectal or intramural abscess, with fistulectomy, or fistulotomy, submuscular, with or without placement of seton
 46080 3 Sphincterotomy, anal, division of sphincter (separate procedure)

EXCISION

- 46200 2 Fissurectomy, with or without sphincterotomy
 46210 2 Cryptectomy; single
 46211 2 Cryptectomy; multiple (separate procedure)
 46220 1 Papillectomy or excision of single tag, anus (separate procedure)
 46250 3 Hemorrhoidectomy, external, complete
 46255 3 Hemorrhoidectomy internal and external, simple
 46257 3 Hemorrhoidectomy internal and external, simple; with fissurectomy
 46258 3 Hemorrhoidectomy internal and external, simple; with fistulectomy, with or without fissurectomy
 46260 3 Hemorrhoidectomy, internal and external, complex or extensive
 46261 4 Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy
 46262 4 Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy
 46270 3 Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
 46275 3 Surgical; submuscular
 46280 4 Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple with or without placement of seton
 46285 1 Closure of anal fistula with rectal advancement flap; second stage

ENDOSCOPY

- 46608 1 Anoscopy; with removal of foreign body
 46610 1 Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
 46611 1 Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique
 46612 1 Anoscopy; with removal of multiple tumors, polyps, or other lesion by snare technique

REPAIR

- 46700 3 Anoplasty, plastic operation for stricture; adult
 46750 3 Sphincteroplasty, anal, for incontinence or prolapse; adult

- 46753 3 Graft (Thiersch operation) for rectal incontinence and/or prolapse
46754 2 Removal of Thiersch wire or suture, anal canal
46760 2 Sphincteroplasty, anal, for incontinence, adult; muscle transplant

DESTRUCTION

- 46922 1 Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
46924 1 Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method
46937 2 Cryosurgery of rectal tumor; benign
46938 2 Cryosurgery of rectal tumor; malignant

LIVERINCISION

- 47000 1 Biopsy of liver, percutaneous needle

BILIARY TRACTINTRODUCTION

- 47510 2 Introduction of percutaneous transhepatic catheter for biliary drainage
47525 1 Change of percutaneous biliary drainage catheter
47530 1 Revision and/or reinsertion of transhepatic T-tube

ENDOSCOPY

- 47552 2 Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic
47553 3 Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple
47554 3 Biliary endoscopy, percutaneous via T-tube or other tract; for removal of stone(s)
47555 3 Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent

EXCISION

- 47630 3 Biliary duct stone extraction, percutaneous via T-tube tract, basket or snare (eg, Burhenne technique)

PANCREASEXCISION

- 48102 1 Biopsy of pancreas, percutaneous needle

ABDOMEN, PERITONEUM, AND OMENTUMINCISION

- 49000 4 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)
49080 2 Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial
49081 2 Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent
49085 2 Removal of peritoneal foreign body from peritoneal cavity

EXCISION AND DESTRUCTION

49180 1 Biopsy, abdominal or retroperitoneal mass, percutaneous needle

INTRODUCTION AND REVISION

49400 1 Injection of air or contrast into peritoneal cavity (separate procedure)
 49420 1 Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary
 49421 1 Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent
 49425 2 Peritoneal-venous shunt (eg, LeVeen shunt)
 49426 2 Revision of peritoneal-venous shunt

HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY

49505 4 Repair initial inguinal hernia, age 5 years or over; reducible
 49520 7 Repair recurrent inguinal hernia, any age; reducible
 49525 4 Repair inguinal hernia, sliding, any age
 49540 2 Repair lumbar hernia
 49550 5 Repair initial femoral hernia, any age; reducible
 49555 5 Repair recurrent femoral hernia; reducible
 49560 4 Repair initial (incisional) hernia; reducible (separate procedure)
 49565 4 Repair recurrent (incisional) hernia; reducible (separate procedure) recurrent
 49570 4 Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)
 49585 4 Repair umbilical hernia, age 5 years or over; reducible
 49590 3 Repair spigelian hernia

URINARY SYSTEMKIDNEYINCISION

50020 2 Drainage of perirenal or renal abscess (separate procedure)
 50040 3 Nephrostomy, nephrotomy with drainage

EXCISION

50200 1 Renal biopsy; percutaneous, by trocar or needle

INTRODUCTION

50390 1 Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
 50392 1 Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
 50393 1 Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous
 50395 1 Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
 50396 1 Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
 50398 1 Change of nephrostomy or pyelostomy tube

SUTURE

50520 1 Closure of nephrocutaneous or pyelocutaneous fistula

ENDOSCOPY

- 50551 1 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
- 50553 1 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
- 50555 1 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
- 50557 1 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
- 50559 1 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration
- 50561 1 Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
- 50570 1 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
- 50572 1 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
- 50574 1 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
- 50576 1 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
- 50578 1 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration
- 50580 1 Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus

OTHER PROCEDURES

- 50590 9 Lithotripsy, extracorporeal shock wave (See §5243.6)

URETERINTRODUCTION

- 50684 1 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter
- 50688 1 Change of ureterostomy tube

- 50690 1 Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service

ENDOSCOPY

- 50951 1 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
- 50953 1 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
- 50955 1 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
- 50957 1 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
- 50959 1 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)
- 50961 1 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
- 50970 1 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
- 50972 1 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter
- 50974 1 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
- 50976 1 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
- 50978 1 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)
- 50980 1 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus

BLADDERINCISION

- 51005 1 Aspiration of bladder; by trocar or intracatheter
- 51010 1 Aspiration of bladder; with insertion of suprapubic catheter
- 51020 4 Cystostomy or cystostomy; with fulguration and/or insertion of radioactive material

- 51030 4 Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion
51045 4 Cystotomy, with insertion of ureteral catheter or stent (separate procedure)

EXCISION

- 51500 4 Excision of urachal cyst or sinus, with or without umbilical hernia repair

INTRODUCTION

- 51600 1 Injection procedure for cystography or voiding urethrocytography
51605 1 Injection procedure and placement of chain for contrast and/or chain urethrocytography
51610 1 Injection procedure for retrograde urethrocytography
51710 1 Change of cystostomy tube; complicated

URODYNAMICS

- 51725 1 Simple cystometrogram (CMG) (eg, spinal manometer)
51726 1 Complex cystometrogram (eg, calibrated electronic equipment)
51772 1 Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique
51785 1 Electromyography studies (EMG) of anal or urethral sphincter, any technique

REPAIR

- 51865 4 Cystorrhaphy, suture of bladder wound, injury or rupture; complicated
51880 1 Closure of cystostomy (separate procedure)
51900 4 Closure of vesicovaginal fistula, abdominal approach
51920 3 Closure of vesicouterine fistula

ENDOSCOPY-CYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY

- 52000 1 Cystourethroscopy (separate procedure)
 52005 2 Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
 52007 2 Cystourethroscopy with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis
 52010 2 Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service

TRANSURETHRAL SURGERY (URETHRA AND BLADDER)

- 52204 2 Cystourethroscopy, with biopsy
 52214 2 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
 52224 2 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
 52234 2 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)
 52235 3 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
 52240 3 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)
 52250 4 Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
 52260 2 Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
 52270 2 Cystourethroscopy, with internal urethrotomy; female
 52275 2 Cystourethroscopy, with internal urethrotomy; male
 52276 3 Cystourethroscopy with direct vision internal urethrotomy
 52277 2 Cystourethroscopy, with resection of external sphincter (sphincterotomy)
 52281 2 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female
 52283 2 Cystourethroscopy, with steroid injection into stricture
 52285 2 Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
 52290 2 Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
 52300 2 Cystourethroscopy; with resection or fulguration of ureterocoele(s), unilateral or bilateral
 52305 2 Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple
 52310 2 Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple

- 52315 2 Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated
- 52317 1 Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments, simple; small (less than 2.5 cm)
- 52318 2 Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments, simple; complicated or large (over 2.5 cm)

TRANSURETHRAL SURGERY (URETER AND PELVIS)

- 52320 5 Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
- 52325 4 Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electrohydraulic technique)
- 52330 2 Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus
- 52332 2 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
- 52334 3 Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde
- 52335 3 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method)
- 52336 4 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method); with removal or manipulation of calculus (urethral catheterization is included)
- 52337 4 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method); with lithotripsy (ureteral catheterization is included)
- 52338 4 Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method); with biopsy and/or fulguration of lesion

TRANSURETHRAL SURGERY (VESICAL NECK AND PROSTATE)

- 52340 3 Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds)
- 52500 3 Transurethral resection of bladder neck (separate procedure)
- 52601 4 Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
- 52606 1 Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time
- 52612 2 Transurethral resection of prostate; first stage of two-stage resection (partial resection)
- 52614 1 Transurethral resection of prostate; second stage of two-stage resection (resection completed)
- 52620 1 Transurethral resection; of residual obstructive tissue after 90 days postoperative
- 52630 2 Transurethral resection; of regrowth of obstructive tissue longer than one year postoperative
- 52640 2 Transurethral resection; of postoperative bladder neck contracture

- 52650 2 Transurethral cryosurgical removal of prostate (postoperative irrigations and aspiration of sloughing tissue included)
- 52700 2 Transurethral drainage of prostatic abscess

URETHRAINCISION

- 53000 1 Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
- 53010 1 Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
- 53020 1 Meatotomy, cutting of meatus (separate procedure); except infant
- 53040 2 Drainage of deep periurethral abscess

EXCISION

- 53200 1 Biopsy of urethra
- 53210 5 Urethrectomy, total, including cystostomy; female
- 53215 5 Urethrectomy, total, including cystostomy; male
- 53220 2 Excision or fulguration of carcinoma of urethra
- 53230 2 Excision of urethral diverticulum (separate procedure); female
- 53235 3 Excision of urethral diverticulum (separate procedure); male
- 53240 2 Marsupialization of urethral diverticulum, male or female
- 53250 2 Excision of bulbourethral gland (Cowper's gland)
- 53260 2 Excision or fulguration; urethral polyp(s), distal urethra
- 53265 2 Excision or fulguration; urethral caruncle
- 53275 2 Excision or fulguration; urethral prolapse

REPAIR

- 53400 3 Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johanssen type)
- 53405 2 Urethroplasty; second stage (formation of urethra), including urinary diversion
- 53410 2 Urethroplasty, one-stage reconstruction of male anterior urethra
- 53420 3 Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
- 53425 2 Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage
- 53430 2 Urethroplasty, reconstruction of female urethra
- 53440 2 Operation for correction of male urinary incontinence, with or without introduction of prosthesis
- 53442 1 Removal of perineal prosthesis introduced for continence
- 53447 1 Removal, repair or replacement of inflatable sphincter including pump and/or reservoir and/or cuff
- 53449 1 Surgical correction of hydraulic abnormality of inflatable sphincter device
- 53450 1 Urethromatoplasty, with mucosal advancement
- 53460 1 Urethromatoplasty, with partial excision of distal urethral segment (Richardson type procedure)

SUTURE

- 53502 2 Urethrorrhaphy, suture of urethral wound or injury; female
- 53505 2 Urethrorrhaphy, suture of urethral wound or injury; penile
- 53510 2 Urethrorrhaphy, suture of urethral wound or injury; perineal
- 53515 2 Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous
- 53520 2 Closure of urethrostomy or urethrocuteaneous fistula, male (separate procedure)

MANIPULATION

- 53605 2 Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
- 53665 1 Dilation of female urethra, general or conduction (spinal) anesthesia

MALE GENITAL SYSTEMPENISINCISION

- 54001 2 Slitting of prepuce, dorsal or lateral (separate procedure); except newborn

DESTRUCTION

- 54057 1 Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
- 54060 1 Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
- 54065 1 Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method

EXCISION

- 54100 1 Biopsy of penis; cutaneous (separate procedure)
- 54105 1 Biopsy of penis; deep structures
- 54110 2 Excision of penile plaque (Payronie disease)
- 54115 1 Removal foreign body from deep penile tissue (eg, plastic implant)
- 54120 2 Amputation of penis; partial
- 54125 2 Amputation of penis; complete
- 54152 1 Circumcision, using clamp or other device; except newborn
- 54161 2 Circumcision, surgical excision other than clamp device or dorsal slit; except newborn

INTRODUCTION

- 54220 1 Irrigation of corpora cavernosa for priapism

REPAIR

- 54300 3 Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
- 54360 3 Plastic operation on penis to correct angulation
- 54420 4 Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral
- 54435 4 Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism
- 54440 4 Plastic operation of penis for injury

MANIPULATION

- 54450 1 Foreskin manipulation including lysis of preputial adhesions and stretching

TESTISEXCISION

- 54500 1 Biopsy of testis, needle (separate procedure)

54505	1	Biopsy of testis, incisional (separate procedure)
54510	2	Excision of local lesion of testis
54520	3	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54530	4	Orchiectomy, radical, for tumor; inguinal approach
54550	4	Exploration for undescended testis (inguinal or scrotal area)

REPAIR

54600	4	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis
54620	3	Fixation of contralateral testis (separate procedure)
54640	4	Orchiopexy, any type, with or without hernia repair
54660	2	Insertion of testicular prosthesis (separate procedure)
54670	3	Suture or repair of testicular injury
54680	3	Transplantation of testis(es) to thigh (because of scrotal destruction)

EPIDIDYMISINCISION

54700	2	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)
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EXCISION

54800	1	Biopsy of epididymis, needle
54820	1	Exploration of epididymis, with or without biopsy
54830	3	Excision of local lesion of epididymis
54840	4	Excision of spermatocele, with or without epididymectomy
54860	3	Epididymectomy; unilateral
54861	4	Epididymectomy; bilateral

REPAIR

54900	4	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901	4	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral

TUNICA VAGINALISEXCISION

55040	3	Excision of hydrocele; unilateral
55041	5	Excision of hydrocele; bilateral

REPAIR

55060	4	Repair of tunica vaginalis hydrocele (Bottle type)
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SCROTUMINCISION

55100	1	Drainage of scrotal wall abscess
55110	2	Scrotal exploration
55120	2	Removal of foreign body in scrotum

EXCISION

55150	1	Resection of scrotum
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REPAIR

55175	1	Scrotoplasty; simple
55180	2	Scrotoplasty; complicated

VAS DEFERENSINCISION

- 55200 2 Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)

REPAIR

- 55400 1 Vasovasostomy, vasovasorrhaphy

SPERMATIC CORDEXCISION

- 55500 3 Excision of hydrocele of spermatic cord, unilateral (separate procedure)
 55520 4 Excision of lesion of spermatic cord (separate procedure)
 55530 4 Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
 55535 4 Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach
 55540 5 Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair

SEMINAL VESICLESINCISION

- 55600 1 Vesiculotomy
 55605 1 Vesiculotomy; complicated

EXCISION

- 55650 1 Vesiculectomy, any approach
 55680 1 Excision of Mullerian duct cyst

PROSTATEINCISION

- 55700 2 Biopsy, prostate; needle or punch, single or multiple, any approach
 55705 2 Biopsy, prostate; incisional any approach
 55720 1 Prostatotomy, external drainage of prostatic abscess, any approach; simple

FEMALE GENITAL SYSTEMENDOSCOPY - LAPAROSCOPY - HYSTEROSCOPY

- 56300 3 Laparoscopy, diagnostic (separate procedure)
 56303 5 Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
 56304 5 Laparoscopy, surgical; with lysis of adhesions
 56305 4 Laparoscopy, surgical; with biopsy (single or multiple)
 56306 4 Laparoscopy, surgical; with aspiration (single or multiple)
 56307 5 Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
 56350 1 Hysteroscopy, diagnostic (separate procedure)
 56352 2 Hysteroscopy, surgical; with lysis of intrauterine adhesions
 56354 3 Hysteroscopy, surgical; with removal of leiomyomata

56360 2	Peritoneoscopy; without biopsy
56361 3	Peritoneoscopy; with biopsy
56362 3	Peritoneoscopy with guided transhepatic cholangiography; without biopsy
56363 3	Peritoneoscopy with guided transhepatic cholangiography; with biopsy

VULVA, PERINEUM AND INTROITUSINCISION

56405 2	Incision and drainage of vulva or perineal abscess
56440 2	Marsupialization of Bartholin's gland cyst

DESTRUCTION

56515 3	Destruction of lesion(s), vulva; extensive, any method
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EXCISION

56605 1	Biopsy of vulva or perineum (separate procedure); one lesion
56620 5	Vulvectomy, simple; partial (less than 80% of vulvar area)
56625 7	Vulvectomy, simple; complete (skin and subcutaneous tissue)
56700 1	Partial hymenectomy or revision of hymenal ring
56720 1	Hymenotomy, simple incision
56740 3	Excision of Bartholin's gland or cyst

REPAIR

56800 3	Plastic repair of introitus
56810 5	Perineoplasty, repair of perineum, non-obstetrical (separate procedure)

VAGINAINCISION

57000 1	Colpotomy; with exploration
57010 2	Colpotomy; with drainage of pelvic abscess
57020 2	Colpocentesis (separate procedure)

DESTRUCTION

57065 1	Destruction of vaginal lesion(s); extensive, any method
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EXCISION

57105 2	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
57130 2	Excision of vaginal septum
57135 2	Excision of vaginal cyst or tumor

INTRODUCTION

57180 1	Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical vaginal hemorrhage (separate procedure)
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REPAIR

57200 1	Colporrhaphy, suture of injury of vagina (nonobstetrical)
57210 2	Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)
57220 3	Plastic operation on urethral sphincter, vaginal approach (eg. Kelly urethral plication)
57230 3	Plastic repair of urethrocele

57240 5	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele
57250 5	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260 5	Combined anteroposterior colporrhaphy
57265 7	Combined anteroposterior colporrhaphy; with enterocele repair
57268 3	Repair of enterocele, vaginal approach (separate procedure)
57300 3	Closure of rectovaginal fistula; vaginal or transanal approach
57310 3	Closure of urethrovaginal fistula
57311 4	Closure of urethrovaginal fistula; with bulbocavernosus transplant
57320 3	Closure of vesicovaginal fistula; vaginal approach

MANIPULATION

57400 2	Dilation of vagina under anesthesia
57410 2	Pelvic examination under anesthesia

CERVIX UTERIEXCISION

57513 2	Cauterization of cervix; laser ablation
57520 2	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair (any method)
57530 3	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57550 3	Excision of cervical stump, vaginal approach

REPAIR

57700 1	Cerclage of uterine cervix, nonobstetrical
57720 3	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach

MANIPULATION

57800 1	Dilation of cervical canal, instrumental (separate procedure)
57820 3	Dilation and curettage of cervical stump

CORPUS UTERIEXCISION

58120 2	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58145 5	Myomectomy, excision of fibroid tumor of uterus, single or multiple (separate procedure); vaginal approach

OVARYINCISION

58800 3	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); vaginal approach
58820 3	Drainage of ovarian abscess; vaginal approach

EXCISION

58900 3	Biopsy of ovary, unilateral or bilateral (separate procedure)
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ENDOCRINE SYSTEMTHYROID GLANDINCISION

60000 1

Incision and drainage of thyroglossal cyst, infected

EXCISION

60200 2

Excision of cyst or adenoma of thyroid, or transection of isthmus

60220	2	Total thyroid lobectomy, unilateral
60225	3	Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmus
60280	4	Excision of thyroglossal duct cyst or sinus
60281	4	Excision of thyroglossal duct cyst or sinus; recurrent

NERVOUS SYSTEMSKULL, MENINGES, AND BRAINPUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION

61020	1	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
61026	1	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; with injection of drug or other substance for diagnosis or treatment
61050	1	Cisternal or lateral cervical (C1-C2) puncture; without injection (separate procedure)
61055	1	Cisternal or lateral cervical (C1-C2) puncture; with injection of drug or other substance for diagnosis or treatment (C1-C2)
61070	1	Puncture of shunt tubing or reservoir for aspiration or injection procedure

TWIST DRILL, BURR HOLE(S) OR TREPHINE

61215	3	Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter
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STEREOTAXIS

61790	3	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion
61791	3	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract

NEUROSTIMULATORS, INTRACRANIAL

61885	2	Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling
61888	1	Revision or removal of cranial neurostimulator pulse generator or receiver

CSF SHUNT

62194	1	Replacement or irrigation, subarachnoid/subdural catheter
62225	1	Replacement or irrigation, ventricular catheter
62230	2	Replacement or revision of CSF shunt, obstructed valve, or distal catheter in shunt system
62256	2	Removal of complete CSF shunt system; without replacement

SPINE AND SPINAL CORDPUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION

62268	1	Percutaneous aspiration, spinal cord cyst or syrinx
62269	1	Biopsy of spinal cord, percutaneous needle

- 62270 1 Spinal puncture, lumbar, diagnostic
- 62272 1 Spinal puncture, therapeutic, for drainage of spinal fluid (by needle or catheter)
- 62273 1 Injection, lumbar epidural, of blood or clot patch
- 62274 1 Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; subarachnoid or subdural, single
- 62276 1 Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; subarachnoid or subdural, differential
- 62277 1 Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; subarachnoid or subdural, continuous
- 62278 1 Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; epidural, lumbar or caudal, single
- 62279 1 Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; epidural, lumbar or caudal, continuous
- 62280 1 Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); subarachnoid
- 62282 1 Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); epidural, lumbar or caudal
- 62288 1 Injection of substance other than anesthetic, contrast, or neurolytic solutions; subarachnoid (separate procedure)
- 62289 1 Injection of substance other than anesthetic, contrast, or neurolytic solutions; lumbar or caudal epidural (separate procedure)
- 62294 3 Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal

STEREOTAXIS

- 63600 2 Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)
- 63610 1 Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery

NEUROSTIMULATORS, SPINAL

- 63650 2 Percutaneous implantation of neurostimulator electrodes; epidural
- 63660 1 Revision or removal of spinal neurostimulator electrodes
- 63685 2 Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
- 63688 1 Revision or removal of implanted spinal neurostimulator pulse generator or receiver

SHUNT, SPINAL CSF

- 63744 3 Replacement, irrigation or revision of lumbosubarachnoid shunt
- 63746 2 Removal of entire lumbosubarachnoid shunt system without replacement
- 63750 4 Insertion, subarachnoid catheter with reservoir and/or pump for intermittent or continuous infusion of drug, including laminectomy
- 63780 2 Insertion or replacement, subarachnoid or epidural catheter, with reservoir and/or pump for drug infusion, without laminectomy

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

SOMATIC NERVES

- | | | |
|-------|---|---|
| 64410 | 1 | Injection, anesthetic agent; phrenic nerve |
| 64415 | 1 | Injection, anesthetic agent; brachial plexus |
| 64417 | 1 | Injection, anesthetic agent; axillary nerve |
| 64420 | 1 | Injection, anesthetic agent; intercostal nerve, single |
| 64421 | 1 | Injection, anesthetic agent; intercostal nerves, multiple, regional block |
| 64430 | 1 | Injection, anesthetic agent; pudendal nerve |
| 64442 | 1 | Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level |
| 64443 | 1 | Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, each additional level |

SYMPATHETIC NERVES

- | | | |
|-------|---|---|
| 64510 | 1 | Injection, anesthetic agent; stellate ganglion (cervical sympathetic) |
| 64520 | 1 | Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic) |
| 64530 | 1 | Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring |

NEUROSTIMULATORS, PERIPHERAL NERVE

- | | | |
|-------|---|---|
| 64575 | 1 | Incision for implantation of neurostimulator electrodes; peripheral nerve |
| 64590 | 2 | Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling |
| 64595 | 1 | Revision or removal of peripheral neurostimulator pulse generator or receiver |

DESTRUCTION BY NEUROLYTIC AGENT (EG, CHEMICAL, THERMAL, ELECTRICAL, RADIOFREQUENCY)

SOMATIC NERVES

- | | | |
|-------|---|--|
| 64600 | 1 | Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch |
| 64605 | 1 | Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale |
| 64610 | 1 | Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring |
| 64620 | 1 | Destruction by neurolytic agent; intercostal nerve |
| 64622 | 1 | Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar, single level |
| 64623 | 1 | Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar, each additional level |
| 64630 | 2 | Destruction by neurolytic agent; pudendal nerve |

SYMPATHETIC NERVES

- | | | |
|-------|---|---|
| 64680 | 2 | Destruction by neurolytic agent, celiac plexus, with or without radiologic monitoring |
|-------|---|---|

NEUROLOPLASTY (EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION)

64702	1	Neuroplasty; digital, one or both, same digit
64704	1	Neuroplasty; nerve of hand or foot
64708	2	Neuroplasty, major peripheral nerve, arm or leg; other than specified
64712	2	Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve
64713	2	Neuroplasty, major peripheral nerve, arm or leg; brachial plexus
64714	2	Neuroplasty, major peripheral nerve, arm or leg; lumbar plexus
64716	3	Neuroplasty and/or transposition; cranial nerve (specify)
64718	2	Neuroplasty and/or transposition; ulnar nerve at elbow
64719	2	Neuroplasty and/or transposition; ulnar nerve at wrist
64721	2	Neuroplasty and/or transposition; median nerve at carpal tunnel
64722	1	Decompression; unspecified nerve(s) (specify)
64726	1	Decompression; plantar digital nerve
64727	1	Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)

TRANSECTION OR AVULSION OF NERVE

64732	2	Transaction or avulsion of; supraorbital nerve
64734	2	Transaction or avulsion of; infraorbital nerve
64736	2	Transaction or avulsion of; mental nerve
64738	2	Transaction or avulsion of; inferior alveolar nerve by osteotomy
64740	2	Transaction or avulsion of; lingual nerve
64742	2	Transaction or avulsion of; facial nerve, differential or complete
64744	2	Transaction or avulsion of; greater occipital nerve
64746	2	Transaction or avulsion of; phrenic nerve
64771	2	Transaction or avulsion of other cranial nerve, extradural
64772	2	Transaction or avulsion of other spinal nerve, extradural

EXCISION-SOMATIC NERVES

64774	2	Excision of neuroma; cutaneous nerve, surgically identifiable
64776	3	Excision of neuroma; digital nerve, one or both, same digit
64778	2	Excision of neuroma; digital nerve, each additional digit (list separately by this number)
64782	3	Excision of neuroma; hand or foot, except digital nerve
64783	2	Excision of neuroma; hand or foot, each additional nerve, except same digit (list separately by this number)
64784	3	Excision of neuroma; major peripheral nerve, except sciatic
64786	3	Excision of neuroma; sciatic nerve
64787	2	Implantation of nerve end into bone or muscle (list separately in addition to neuroma excision)
64788	3	Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790	3	Excision of neurofibroma or neurolemmoma; major peripheral nerve
64792	3	Excision of neurofibroma or neurolemmoma; extensive (including malignant type)
64795	2	Biopsy of nerve

EXCISION-SYMPATHETIC NERVES

64802	2	Sympathectomy, cervical
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NERVE REPAIR BY SUTURE (NEUORRRHAPHY)

- | | | |
|-------|---|---|
| 64830 | 5 | Microdissection and/or microrepair of nerve (list separately in addition to code for nerve repair) |
| 64831 | 4 | Suture of digital nerve, hand or foot; one nerve |
| 64832 | 1 | Suture of digital nerve, hand or foot; each additional digital nerve |
| 64834 | 2 | Suture of one nerve, hand or foot; common sensory nerve |
| 64835 | 3 | Suture of one nerve, hand or foot; median motor thenar |
| 64836 | 3 | Suture of one nerve, hand or foot; ulnar motor |
| 64837 | 1 | Suture of each additional nerve, hand or foot |
| 64840 | 2 | Suture of posterior tibial nerve |
| 64856 | 2 | Suture of major peripheral nerve, arm or leg, except sciatic; including transposition |
| 64857 | 2 | Suture of major peripheral nerve, arm or leg, except sciatic; without transposition |
| 64858 | 2 | Suture of sciatic nerve |
| 64859 | 1 | Suture of each additional major peripheral nerve |
| 64861 | 3 | Suture of; brachial plexus |
| 64862 | 3 | Suture of; lumbar plexus |
| 64864 | 3 | Suture of facial nerve; extracranial |
| 64865 | 4 | Suture of facial nerve; intratemporal, with or without grafting |
| 64870 | 4 | Anastomosis; facial-phrenic |
| 64872 | 2 | Suture of nerve; requiring secondary or delayed suture (list separately in addition to code for primary neurorrhaphy) |
| 64874 | 3 | Suture of nerve; requiring extensive mobilization, or transposition of nerve (list separately in addition to code for nerve suture) |
| 64876 | 3 | Suture of nerve; requiring shortening of bone of extremity (list separately in addition to code for nerve suture) |

NEUORRRHAPHY WITH NERVE GRAFT

- | | | |
|-------|---|---|
| 64890 | 2 | Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length |
| 64891 | 2 | Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length |
| 64892 | 2 | Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length |
| 64893 | 2 | Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length |
| 64895 | 3 | Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length |
| 64896 | 3 | Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length |
| 64897 | 3 | Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length |
| 64898 | 3 | Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length |
| 64901 | 2 | Nerve graft, each additional nerve; single strand |
| 64902 | 2 | Nerve graft, each additional nerve; multiple strands (cable) |
| 64905 | 2 | Nerve pedicle transfer; first stage |
| 64907 | 1 | Nerve pedicle transfer; second stage |

EYE and OCULAR ADNEXA

EYEBALLREMOVAL OF EYE

- | | | |
|-------|---|--|
| 65091 | 3 | Evisceration of ocular contents; without implant |
| 65093 | 3 | Evisceration of ocular contents; with implant |
| 65101 | 3 | Enucleation of eye; without implant |
| 65103 | 3 | Enucleation of eye; with implant, muscles not attached to implant |
| 65105 | 4 | Enucleation of eye; with implant, muscles attached to implant |
| 65110 | 5 | Exenteration of orbit (does not include skin graft), removal of orbital contents; only |
| 65112 | 7 | Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone |
| 65114 | 7 | Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap |

SECONDARY IMPLANT PROCEDURES

- | | | |
|-------|---|---|
| 65130 | 3 | Insertion of ocular implant secondary; after evisceration, in scleral shell |
| 65135 | 2 | Insertion of ocular implant secondary; after enucleation, muscles not attached to implant |
| 65140 | 3 | Insertion of ocular implant secondary; after enucleation, muscles attached to implant |
| 65150 | 2 | Reinsertion of ocular implant; with or without conjunctival graft |
| 65155 | 3 | Reinsertion of ocular implant; with use of foreign material for reinforcement and/or attachment of muscles to implant |
| 65175 | 1 | Removal of ocular implant |

REMOVAL OF OCULAR FOREIGN BODY

- | | | |
|-------|---|--|
| 65235 | 2 | Removal of foreign body, intraocular; from anterior chamber, or lens |
| 65260 | 3 | Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route |
| 65265 | 4 | Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction |

REPAIR OF LACERATION OF EYEBALL

- | | | |
|-------|---|---|
| 65270 | 2 | Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure |
| 65272 | 2 | Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization |
| 65275 | 4 | Repair of laceration; cornea, nonperforating, with or without removal foreign body |
| 65280 | 4 | Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue |
| 65285 | 4 | Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue |
| 65290 | 3 | Repair of wound, extraocular muscle, tendon and/or Tenon's capsule |

ANTERIOR SEGMENT - CORNEAEXCISION

- | | | |
|-------|---|---|
| 65400 | 1 | Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium |
| 65410 | 2 | Biopsy of cornea |

- 65420 2 Excision or transposition of pterygium; without graft
 65426 5 Excision or transposition of pterygium; with graft

KERATOPLASTY

- 65710 7 Keratoplasty (corneal transplant); lamellar
 65730 7 Keratoplasty (corneal transplant); penetrating (except in aphakia)
 65750 7 Keratoplasty (corneal transplant); penetrating, (in aphakia)
 65755 7 Keratoplasty (corneal transplant); penetrating (in pseudophakia)

ANTERIOR SEGMENT - ANTERIOR CHAMBERINCISION

- 65800 1 Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous
 65805 1 Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous
 65810 3 Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or dissection of anterior hyaloid membrane, with or without air injection
 65815 2 Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection
 65850 4 Trabeculectomy ab externo

OTHER PROCEDURES

- 65865 1 Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); goniosynechiae
 65870 4 Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae
 65875 4 Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae
 65880 4 Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid)
 65900 5 Removal of epithelial downgrowth, anterior chamber eye
 65920 7 Removal of implanted material, anterior segment eye
 65930 5 Removal of blood clot, anterior segment eye
 66020 1 Injection, anterior chamber (separate procedure); air or liquid
 66030 1 Injection, anterior chamber (separate procedure); medication

ANTERIOR SEGMENT - ANTERIOR SCLERAEXCISION

- 66130 7 Excision of lesion, sclera
 66150 4 Fistulization of sclera for glaucoma; trephination with iridectomy
 66155 4 Fistulization of sclera for glaucoma; thermocauterization with iridectomy
 66160 2 Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy

- 66165 4 Fistulization of sclera for glaucoma; iridencleisis or iridotaxis
66170 4 Fistulization of sclera for glaucoma; trabeculectomy ab externo
66172 4 Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)

REPAIR

- 66220 3 Repair of scleral staphyloma; without graft
66225 4 Repair of scleral staphyloma; with graft

REVISION OPERATIVE WOUND

- 66250 2 Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure

ANTERIOR SEGMENT - IRIS, CILIARY BODYIRIDOTOMY, IRIDECTOMY

- 66500 1 Iridotomy by stab incision (separate procedure); except transfixion
66505 1 Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe
66600 3 Iridectomy, with corneoscleral or corneal section; for removal of lesion
66605 3 Iridectomy, with corneoscleral or corneal section; with cyclotomy
66625 3 Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)
66630 3 Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure)
66635 3 Iridectomy, with corneoscleral or corneal section; "optical" (separate procedure)

REPAIR

- 66680 3 Repair of iris, ciliary body (as for iridodialysis)
66682 2 Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (eg, McCannel suture)

DESTRUCTION

- 66700 2 Ciliary body destruction; diathermy
66710 2 Ciliary body destruction; cyclophotocoagulation
66720 2 Ciliary body destruction; cryotherapy
66740 2 Ciliary body destruction; cycloablation
66762 1 Iridoplasty by photocoagulation (one or more sessions) eg, for improvement of vision, for widening of anterior chamber angle)

ANTERIOR SEGMENT - LENSINCISION

- 66821 2 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages)

REMOVAL CATARACT

- | | | |
|-------|---|---|
| 66830 | 4 | Removal of secondary membranous cataract ("opacified posterior lens capsule and/or anterior hyalod) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy) |
| 66840 | 4 | Removal of lens material; aspiration technique, one or more stages |
| 66850 | 7 | Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration |
| 66852 | 4 | Removal of lens material; pars plana approach, with or without vitrectomy |
| 66920 | 4 | Removal of lens material; intracapsular |
| 66930 | 5 | Removal of lens material; intracapsular, for dislocated lens |
| 66940 | 5 | Removal of lens material; extracapsular (other than 66840, 66850, 66852) |
| 66983 | 8 | Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure) |
| 66984 | 8 | Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration of phacoemulsification) |
| 66985 | 6 | Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal |
| 66986 | 6 | Exchange of intraocular lens |

POSTERIOR SEGMENT - VITREOUS

- | | | |
|-------|---|--|
| 67005 | 4 | Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal |
| 67010 | 4 | Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy |
| 67015 | 1 | Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy) |
| 67025 | 1 | Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration (separate procedure) |
| 67030 | 1 | Dissection of vitreous strands (without removal), pars plana approach |
| 67031 | 2 | Serving of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages) |
| 67036 | 4 | Vitrectomy, mechanical, pars plana approach |
| 67038 | 5 | Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping |
| 67039 | 7 | Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation |
| 67040 | 7 | Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation |

POSTERIOR SEGMENT - RETINAL DETACHMENTREPAIR

- | | | |
|-------|---|---|
| 67101 | 4 | Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid |
| 67105 | 5 | Repair of retinal detachment, one or more sessions; photocoagulation (laser or xenon arc, one or more sessions), with or without drainage of subretinal fluid |

- 67107 5 Repair of retinal detachment, one or more sessions; scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant, may include procedures 67101, 67105
- 67108 7 Repair of retinal detachment, one or more sessions; with vitrectomy, any method, with or without air or gas tamponade, with or without focal endolaser photocoagulation, may include procedures 67101-67107 and/or removal of lens by same technique
- 67109 5 Repair of retinal detachment, one or more sessions; by technique other than 67101-67108 and 67110
- 67112 7 Repair of retinal detachment, one or more sessions; previously operated upon, any technique
- 67115 2 Release of encircling material (posterior segment)
- 67120 2 Removal of implanted material, posterior segment; extraocular
- 67121 2 Removal of implanted material, posterior segment; intraocular

PROPHYLAXIS

- 67141 2 Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy

POSTERIOR SEGMENT - OTHER PROCEDURESDESTRUCTION - RETINA, CHOROID

- 67208 1 Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy
- 67218 5 Destruction of localized lesion of retina (eg, maculopathy choroidopathy, small tumors), one or more sessions; radiation by implantation of source (includes removal of source)
- 67227 1 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy

SCLERAL REPAIR

- 67250 3 Scleral reinforcement (separate procedure); without graft
- 67255 3 Scleral reinforcement (separate procedure); with graft

OCULAR ADNEXA - EXTRAOCULAR MUSCLES

- 67311 3 Strabismus surgery, recession or resection procedure (patient not previously operated on); one horizontal muscle
- 67312 4 Strabismus surgery, recession or resection procedure (patient not previously operated on); two horizontal muscles
- 67314 4 Strabismus surgery, recession or resection procedure (patient not previously operated on); one vertical muscle (excluding superior oblique)
- 67316 4 Strabismus surgery, recession or resection procedure (patient not previously operated on); two or more vertical muscles (excluding superior oblique)
- 67318 4 Strabismus surgery, any procedure (patient not previously operated on), superior oblique muscle
- 67320 4 Transposition procedure (eg, for parietic extraocular muscle), any extraocular muscle (specify)
- 67331 4 Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles

- 67332 4 Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy)

OTHER PROCEDURES

- 67350 1 Biopsy of extraocular muscle

OCULAR ADNEXA - ORBITEXPLORATION, EXCISION, DECOMPRESSION

- 67400 3 Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy
 67405 4 Orbitotomy without bone flap (frontal or transconjunctival approach); with drainage only
 67412 5 Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion
 67413 5 Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body
 67415 1 Fine needle aspiration of orbital contents
 67420 5 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion
 67430 5 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of foreign body
 67440 5 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with drainage or window
 67450 5 Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); for exploration, with or without biopsy

OTHER PROCEDURES

- 67550 4 Orbital implant (implant outside muscle cone); insertion
 67560 2 Orbital implant (implant outside muscle cone); removal or revision

OCULAR ADNEXA - EYELIDSINCISION

- 67715 1 Canthotomy (separate procedure)

EXCISION OR REMOVAL OF LESION INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)

- 67808 2 Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple
 67830 2 Correction of trichiasis; incision of lid margin
 67835 2 Correction of trichiasis; incision of lid margin, with free mucous membrane graft

TARSORRHAPHY

- 67880 3 Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy
 67882 3 Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate

REPAIR OF BROW/PTOSIS BLEPHAROPTOSIS, LID RETRACTION

- 67901 5 Repair of blepharoptosis; frontalis muscle technique with suture or other material
 67902 5 Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)

67903	4	Repair of blepharoptosis; (tarso)levator resection or advancement, internal approach
67904	4	Repair of blepharoptosis; (tarso)levator resection or advancement, external approach
67906	5	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	4	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-lelevator resection (eg, Fasanella-Servat type)
67909	4	Reduction of overcorrection of ptosis
67911	3	Correction of lid retraction

REPAIR ECTROPION, ENTROPION

67914	3	Repair of ectropion; suture
67916	4	Repair of ectropion; blepharoplasty, excision tarsal wedge
67917	4	Repair of ectropion; blepharoplasty, extensive (eg, Kuhn-Szymanowski or tarsal strip operations)
67921	3	Repair of entropion; suture
67923	4	Repair of entropion; blepharoplasty, excision tarsal wedge
67924	4	Repair of entropion; blepharoplasty, extensive (eg, Wheeler operation)

RECONSTRUCTIVE SURGERY, BLEPHAROPLASTY INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)

67935	2	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva) direct closure; full thickness
67950	2	Canthoplasty (reconstruction of canthus)
67961	3	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin
67966	3	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
67971	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage
67973	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, one stage or first stage
67974	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, one stage or first stage
67975	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage

OCULAR ADNEXA - CONJUNCTIVAEXCISION, DESTRUCTION

68130	2	Excision of lesion, conjunctiva; with adjacent sclera
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CONJUNCTIVOPLASTY

68320	4	Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325	4	Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)

68326	4	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
68328	4	Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)
68330	4	Repair of symblepharon; conjunctivoplasty, without graft
68335	4	Repair of symblepharon; with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)
68340	4	Repair of symblepharon; division of symblepharon with or without insertion of conformer or contact lens

OTHER PROCEDURES

68360	2	Conjunctival flap; bridge or partial (separate procedure)
68362	2	Conjunctival flap; total (such as Gunderson thin flap or purse string flap)

OCULAR ADNEXA - LACRIMAL SYSTEMEXCISION

68500	3	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505	3	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial
68510	1	Biopsy of lacrimal gland
68520	3	Excision of lacrimal sac (dacryocystectomy)
68525	1	Biopsy of lacrimal sac
68540	3	Excision of lacrimal gland tumor; frontal approach
68550	3	Excision of lacrimal gland tumor; involving osteotomy

REPAIR

68700	2	Plastic repair of canaliculi
68720	4	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
68745	4	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
68750	4	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent

PROBING AND RELATED PROCEDURES

68825	2	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; requiring general anesthesia
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AUDITORY SYSTEMEXTERNAL EAREXCISION

69110	1	Excision external ear; partial, simple repair
69120	2	Excision external ear; complete amputation
69140	2	Excision exostosis(es), external auditory canal
69145	2	Excision soft tissue lesion, external auditory canal
69150	3	Radical excision external auditory canal lesion; without neck dissection

REMOVAL OF FOREIGN BODY

69205	1	Removal of foreign body from external auditory canal; with general anesthesia
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REPAIR

- 69310 3 Reconstruction of external auditory canal (meatoplasty)(eg, for stenosis due to trauma, infection), (separate procedure)
 69320 7 Reconstruction external auditory canal for congenital atresia, single stage

MIDDLE EARINCISION

- 69421 3 Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
 69424 1 Ventilating tube removal when originally inserted by another physician
 69436 3 Tympanostomy (requiring insertion of ventilating tube), general anesthesia
 69440 3 Middle ear exploration through postauricular or ear canal incision
 69450 1 Tympanolysis, transcanal

EXCISION

- 69501 7 Transmastoid antrotomy ("simple" mastoidectomy)
 69502 7 Mastoidectomy; complete
 69505 7 Mastoidectomy; modified radical
 69511 7 Mastoidectomy; radical
 69530 7 Petrous apicectomy including radical mastoidectomy
 69550 5 Excision aural glomus tumor; transcanal
 69552 7 Excision aural glomus tumor; transmastoid

REPAIR

- 69601 7 Revision mastoidectomy; resulting in complete mastoidectomy
 69602 7 Revision mastoidectomy; resulting in modified radical mastoidectomy
 69603 7 Revision mastoidectomy; resulting in radical mastoidectomy
 69604 7 Revision mastoidectomy; resulting in tympanoplasty
 69605 7 Revision mastoidectomy; with apicectomy
 69620 2 Myringoplasty (surgery confined to drumhead and donor area)
 69631 5 Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
 69632 5 Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction
 69633 5 Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, PORP), total ossicular replacement prosthesis (TORP)
 69635 7 Tympanoplasty with antrotomy or mastoidectomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
 69636 7 Tympanoplasty with antrotomy or mastoidectomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
 69637 7 Tympanoplasty with antrotomy or mastoidectomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis (TORP)

- 69641 7 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
- 69642 7 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction
- 69643 7 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
- 69644 7 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
- 69645 7 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
- 69646 7 Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
- 69650 7 Stapes mobilization
- 69660 5 Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material
- 69661 5 Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out
- 69662 5 Revision of stapedectomy or stapedotomy
- 69666 4 Repair oval window fistula
- 69667 4 Repair round window fistula
- 69670 3 Mastoid obliteration (separate procedure)
- 69676 3 Tympanic neurectomy

OTHER PROCEDURES

- 69700 3 Closure postauricular fistula, mastoid (separate procedure)
- 69710 3 Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
- 69711 1 Removal or repair of electromagnetic bone conduction hearing device in temporal bone
- 69720 5 Decompression facial nerve, intratemporal; lateral to geniculate ganglion
- 69725 5 Decompression facial nerve, intratemporal; including medial to geniculate ganglion
- 69740 5 Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion
- 69745 5 Suture facial nerve, intratemporal, with or without graft or decompression; including medial to geniculate ganglion

INNER EARINCISION, DESTRUCTION

- 69801 5 Labyrinthotomy, with or without cryosurgery or other nonexcisional destructive procedures or tack procedure; transcanal
- 69802 7 Labyrinthotomy, with or without cryosurgery or other nonexcisional destructive procedures or tack procedure; with mastoidectomy
- 69805 7 Endolymphatic sac operation; without shunt
- 69806 7 Endolymphatic sac operation; with shunt
- 69820 5 Fenestration semicircular canal

69840 5 Revision fenestration operation

EXCISION

69905 7 Labyrinthectomy; transcanal
69910 7 Labyrinthectomy; with mastoidectomy
69915 7 Vestibular nerve section, translabyrinthine approach

INSERTION

69930 7 Cochlear device implantation, with or without mastoidectomy

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